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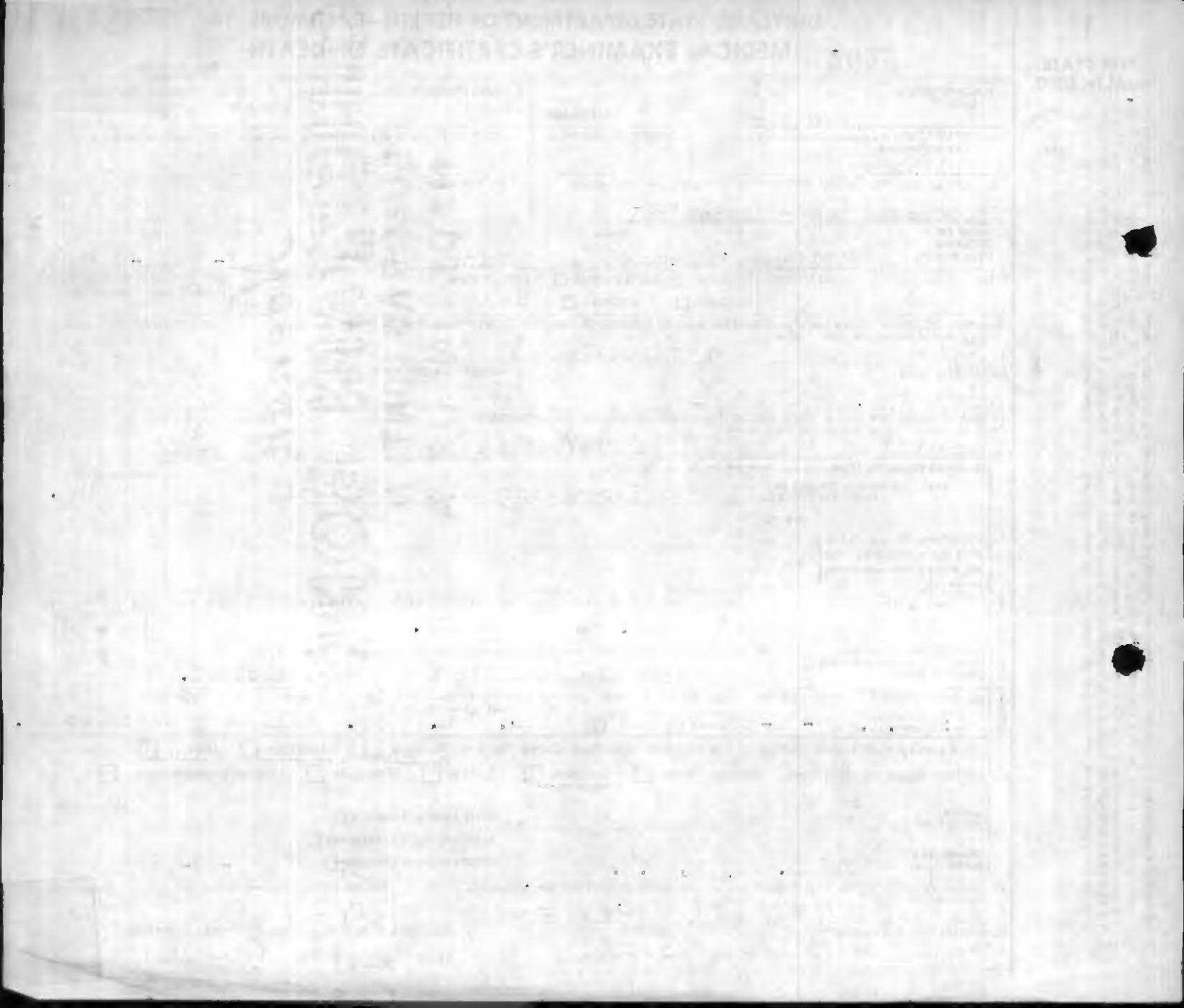
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any part is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PHA3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE	
Wicomico MARYLAND		Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb	
Salisbury		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
Peninsula General Hospital		Newark	
3. NAME OF DECEASED (Type or print)		First	Middle
William HENDERSON			Adkins
4. DATE OF DEATH		Month	Day
		7-	22-
		19 58	
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
M W		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH
		JAN. 23, 1890	
9. AGE (In years, last birthday)		10. IF UNDER 1 YEAR	11. IF UNDER 24 HRS.
68 yrs.		Months	Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
SALESMAN		WATKINS PRODUCTS	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
NEWARK MD		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
JAMES S. ADKINS		ANNIE HENDERSON	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
(If yes, give name and dates of service)		17. INFORMANT	
		Mrs. W. H. ADKINS Berlin MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		Address	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Cardiac arrest under anesthesia	
954X		INTERVAL BETWEEN ONSET AND DEATH Sudden.	
DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)	
		DUE TO	
		(c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Bleeding duodenal ulcer: severe anemia.			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
		Cardiac arrest while being anesthetized.	
20c. TIME OF INJURY 1:08 P.M. 7-22-58		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Pen. Gen. Hosp. Salisbury Wicomico Md.
		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Earl L. Royer</i>		DATE SIGNED 7-22-58	
EXAMINER'S NAME (Type) Earl L. Royer, M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/25/58	22c. NAME OF CEMETERY OR CREMATORIUM Bowen
22d. LOCATION (City, town, or county) Newark		(State) MD.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Anna A. Burdage Berlin Md.</i>		ADDRESS	24a. REC'D BY REGISTRAR DATE JUL 25 '58
		24b. REGISTRAR'S SIGNATURE <i>Alfredine!</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8495

CERTIFICATE OF DEATH

Reg. No. 8497

1. PLACE OF DEATH a. COUNTY Wicomico		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE VIRGINIA		b. COUNTY Accomac		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SALISBURY		c. LENGTH OF STAY IN 1b 3 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) NEW CHURCH		d. STREET ADDRESS KELLY's Camp		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION PENINSULA GENERAL HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) PRISCILLA		First	Middle	Last	4. DATE OF DEATH ALVARADO	Month	Day	Year
5. SEX FEMALE		6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 7, 1956	9. AGE (In years last birthday) 1 yrs.	10. UNDER 1 YR Months 10	11. UNDER 24 HRS Days 18	12. CITIZEN OF WHAT COUNTRY? U.S.A.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY Florida		11. BIRTHPLACE (State or foreign country) Estefania Nieves				
13. FATHER'S NAME FRANCISCO ALVARADO		14. MOTHER'S MAIDEN NAME Estefania Nieves				Address Estefania Alvarado - New church		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? [Yes, no, or unknown] No		16. SOCIAL SECURITY NO. [If yes, give war or dates of service]		17. INFORMANT Estefania Alvarado - New church		INTERVAL BETWEEN ONSET AND DEATH 5 days		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 053.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		Congestive Heart Failure and Pneumonia Staphylococci Septicemia		DEATH CONDITION GIVEN IN PART I(a) 4 days				
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Collapsia with deliriation, (2) Ascariasis		ADDRESS (Street, city or town, state) M.D. - 702 London Ave Salisbury, Md		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 7-22-1958, to 7-25-1958		20f. (City or town) (County) (State) Salisbury, Md		
21. I certify that I attended the deceased from 7-22-1958, to 7-25-1958 that I last saw the deceased alive on 7-25-1958 , and that death occurred at 11:45 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE R. B. Wharton Jr. ADDRESS 702 London Ave DATE SIGNED 7/26/58 PHYSICIAN'S NAME (Type) Edgar Wharton - New Church, etc.								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-26-58		22c. NAME OF CEMETERY OR CREMATORIUM R.B. Wharton mem.		22d. LOCATION (City, town, or county) (State) Parksley, Va		
23. FUNERAL DIRECTOR'S SIGNATURE Edgar Wharton - New Church, etc.		ADDRESS		24a. REC'D BY REGISTRAR DATE JUL 29 '58		24b. REGISTRAR'S SIGNATURE Alfred E. Deacon		

01 2020WASH-STATE OF WASHINGTON

CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as a burial transit permit. Then please remove carbon paper. Page 3 and 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										108498					
8496 CERTIFICATE OF DEATH										Reg. Dist. No.					
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u>					2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>MARYLAND</u>					b. COUNTY <u>Wicomico</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wetipgwin</u>			d. STREET ADDRESS <u>R.F.D. # 2</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>															
3. NAME OF DECEASED (Type or print)		First <u>Ethel</u>	Middle <u></u>	Last <u>Bailey</u>	4. DATE OF DEATH <u>July 11 1958</u>	Month <u>July</u>	Day <u>11</u>	Year <u>1958</u>							
5. SEX <u>Female</u>		6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/14/1885</u>	9. AGE (In years last birthday) <u>73 yrs.</u>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>domestic</u>	11. KIND OF BUSINESS OR INDUSTRY <u>Izola Brown</u>	12. BIRTHPLACE (State or foreign country) <u>Maryland</u>	13. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	IF UNDER 1 YEAR Months <u>1243</u>	IF UNDER 24 HRS. Days <u>1</u>	Hours <u>00</u>	Min. <u>00</u>		
10a. FATHER'S NAME <u>Henry Dashell</u>		14. MOTHER'S MIDDLE NAME <u>Annie Stewart</u>													
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>219-05-3732</u>		17. INFORMANT <u>Izola Brown</u>		Address <u>91. Carey St. 17</u>									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]															
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>446x</u> DUE TO <u>Arteriosclerosis</u> INTERVAL BETWEEN Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) DUE TO <u>Arteriosclerosis</u> ONSET AND DEATH <u>5 years</u> Address <u>600 S.</u>															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Arthritis</u>															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>													
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <u>Wetipgwin</u>		(County) <u>Wetipgwin</u>		(State) <u>Md.</u>					
21. I certify that I attended the deceased from <u>15 March 1958</u> to <u>11 July 1958</u> that I last saw the deceased alive on <u>11 July 1958</u> , and that death occurred at <u>3:15 P.M.</u> from the causes and on the date stated above.															
ACTUAL SIGNATURE <u>Richard H. Saunders M.D.</u> ADDRESS (Street, city or town, state) <u>Wetipgwin Md.</u> DATE SIGNED <u>7/11/58</u>															
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL 7/15/58</u>		22b. DATE THEREOF <u>06/15/58</u>		22c. NAME OF CEMETERY OR CREMATORIAL <u>Odd Fellows</u>		22d. LOCATION (City, town, or county) <u>Wetipgwin</u>		(State) <u>Md.</u>							
23. FUNERAL DIRECTOR'S SIGNATURE <u>Clinton F. Stewart Salisbury Md.</u>		ADDRESS <u>Clinton F. Stewart Salisbury Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 21 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. E. Adams</u>									

• 2019 RELEASE UNDER E.O. 14176 ITAR REGULATED ITEM

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as a burial-transit permit. Then please remove carbon paper. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8497

CERTIFICATE OF DEATH

08499

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN lb 9 days		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Worcester	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ocean City		d. STREET ADDRESS 215 Wicomico Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Prince	Middle Edward	Last Bass	4. DATE OF DEATH July	Month July	Day 17	Year 19 58		
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/27/1904	9. AGE (In years last birthday) 53 yrs.	IF UNDER 1 YEAR Months 53	IF UNDER 24 HRS. Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook		10b. KIND OF BUSINESS OR INDUSTRY Cooking		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Richard Bass				14. MOTHER'S MAIDEN NAME ? Harris					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Unk.		16. SOCIAL SECURITY NO. 7		17. INFORMANT Hospital Records		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis								INTERVAL BETWEEN ONSET AND DEATH 5 minutes	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Arteriosclerotic cardiovascular disease, de- compensated (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic varicose ulceration of both legs								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from July 8, 1958 , to July 17, 1958 , that I last saw the deceased alive on July 17, 1958 , and that death occurred at 1:20 A.M. from the causes and on the date stated above.									
ADDRESS (Street, city or town, state) Deer's Head State Hospital									
DATE SIGNED 7/17/58									
ACTUAL SIGNATURE Dr V Juerman									
M.D.									
PHYSICIAN'S NAME (Type) V. Juerman, M. D.									
Salisbury, Maryland									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 7-21-58		22b. DATE THEREOF 7-21-58		22c. NAME OF CEMETERY OR CREMATORIAL Bellamy Green Cemetery		22d. LOCATION (City, town, or county) Wicomico Co			
(State)									
23. FUNERAL DIRECTOR'S SIGNATURE Bethel M. Welsh		ADDRESS		24a. REC'D BY REGISTRAR DATE JUL 21 '58		24b. REGISTRAR'S SIGNATURE W. A. Lewis			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8547

CERTIFICATE OF DEATH

Reg. Dist. No.

108500

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
<i>Decomis</i>		a. STATE <i>Md</i> b. COUNTY <i>Charles</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <i>Paul</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Lucy</i>		First <i>J.</i>	Middle <i>Birckett</i>
Last <i>J.</i>		4. DATE OF DEATH	Month <i>7</i> Day <i>9</i> Year <i>1958</i>
5. SEX <i>Female</i>	6. COLOR OR RACE <i>C</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3-5-02</i>
9. AGE (In years last birthday) <i>56 yrs.</i>		10. IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>none</i>		11b. KIND OF BUSINESS OR INDUSTRY <i>none</i>	11c. BIRTHPLACE (State or foreign country) <i>Debton Md</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>?</i>		14. MOTHER'S MAIDEN NAME <i>Walter Cart.</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>?</i>	17. INFORMANT <i>Walter Cart.</i>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>1443X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Hypnagogia</i> DUE TO (c) <i>Hypertension</i>		<i>Chronic Hypnagogia 3 1/2 years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Generalized Epilepsia</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>fall</i>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m. <i>19</i>		20d. INJURY OCCURRED White <input type="checkbox"/> Not-white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>400 E. Boucher St.</i>
20f. (City or town) <i>Baltimore</i>		(County) <i>Salisbury</i>	(State) <i>Md.</i>
21. I certify that I attended the deceased from <i>July 7, 1958</i> , to <i>July 9, 1958</i> , that I last saw the deceased alive on <i>July 7, 1958</i> , and that death occurred at <i>501 M.</i> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>501 M. E. Boucher St., Baltimore, Maryland.</i>	
ACTUAL SIGNATURE <i>G. Herbert Sembley M.D.</i>		DATE SIGNED <i>7/10/58</i>	
PHYSICIAN'S NAME (Type) <i>G. Herbert Sembley</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>7-12-58</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Kosciusko Cemetery</i>
22d. LOCATION (City, town, or county) <i>Baltimore</i>		(State) <i>Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Dorothy M. West</i>		24a. REC'D BY REGISTRAR <i>11-11-58</i>	24b. REGISTRAR'S SIGNATURE <i>DeLoach</i>
ADDRESS <i>130 Salisbury Rd.</i>		DATE <i>11-11-58</i>	

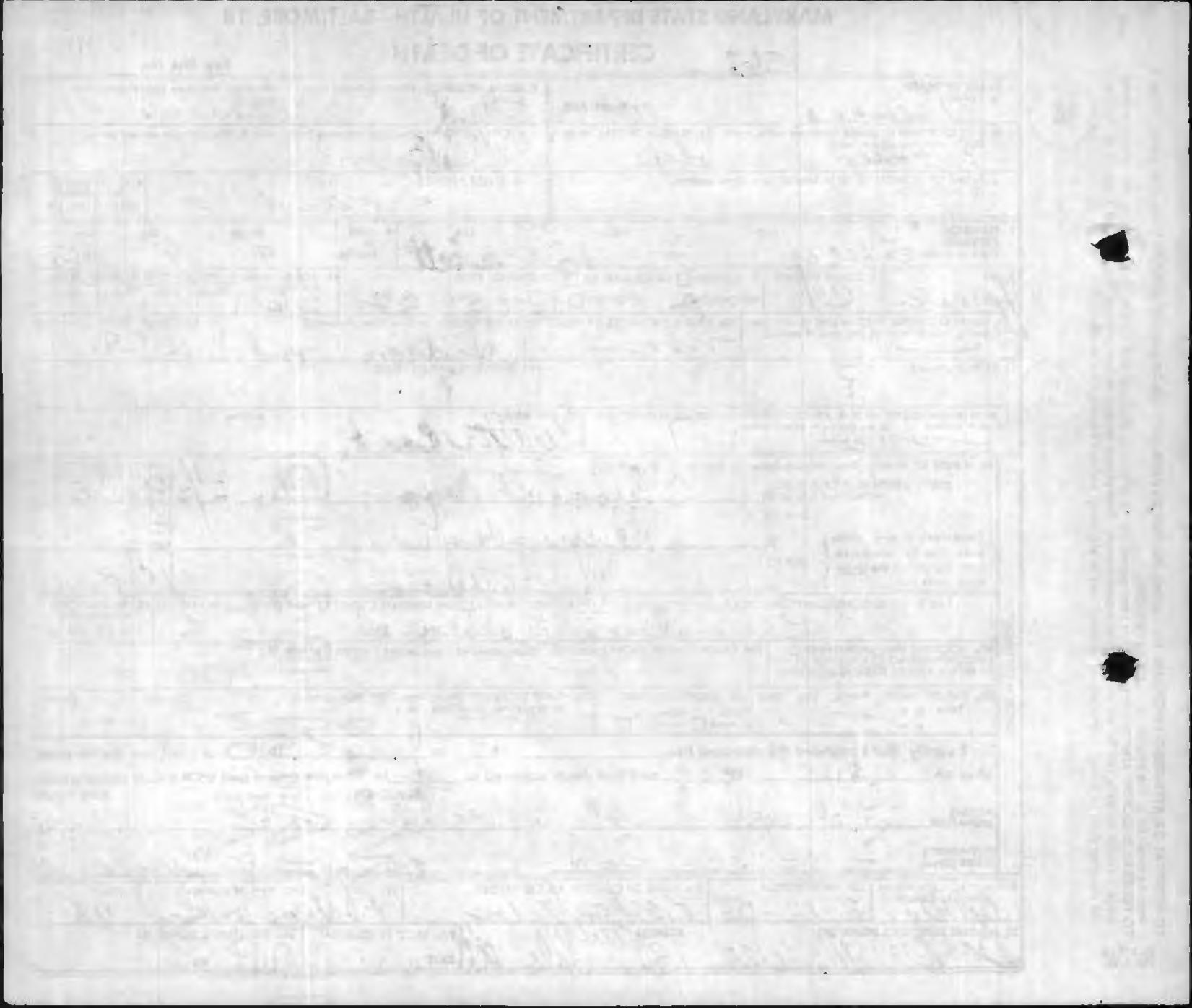
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as a burial-tranit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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WILCOX STADIUM

100



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8498

CERTIFICATE OF DEATH

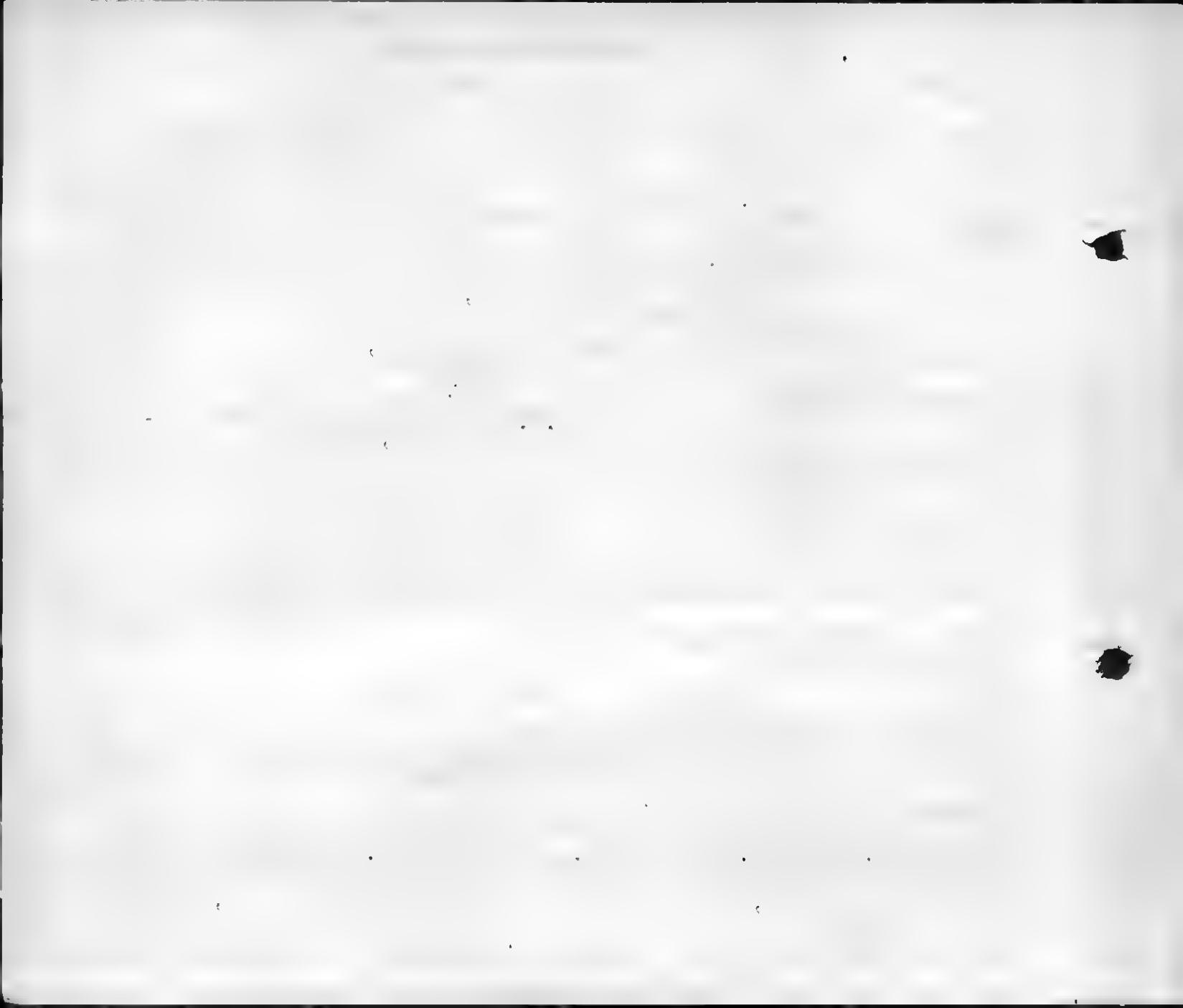
08501

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico		2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		b. COUNTY Wicomico	
c. LENGTH OF STAY IN 1b Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen Gen. Hospital		d. STREET ADDRESS 736 Roger St	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First BERTHA		Middle MAE	Last BOZMAN
4. DATE OF DEATH July 8 th 1958		Month	Day Year
S. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH May 9, 1896
		9. AGE (In years less birthday) 62 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work at Home		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Salisbury, Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Lewis Hastings		14. MOTHER'S MAIDEN NAME Martha Ellen Taylor	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) No		16. SOCIAL SECURITY NO. J7. INFORMANT Mr. N. Granville Bozman (Husband) Address Salisbury, Maryland 736 Roger St	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 days Arteriosclerotic Cardiovascular Disease Years	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 710X Diabetes Mellitus		20. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7/14, 1958, to 7/18, 1958, that I last saw the deceased alive on 7/17, 1958, and that death occurred at 7/18 M, from the causes and on the date stated above. ACTUAL SIGNATURE Rufus S. Gardner Jr.		ADDRESS (Street, city or town, state) Dr. Rufus S. Gardner Jr. Pine Bluff Rd. Salisbury, Maryland DATE SIGNED July 1 / 1958	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF July 10, 1958	
22c. NAME OF CEMETERY OR CREMATORIAL Wicomico Memorial Park		22d. LOCATION (City, town, or county) Salisbury, Maryland (State)	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		24a. REC'D BY REGISTRAR ADDRESS SALISBURY MARYLAND DATE JUL 9 '58	
		24b. REGISTRAR'S SIGNATURE Alfred E. Cook	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as a burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 1
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as a burial-transit permit. Then please remove carbon paper. Page 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18											
1 8499 CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <i>Wicomico</i>				2. USUAL RESIDENCE [Where deceased lived. If institution, Residence before admission] a. STATE <i>Virginia</i>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Salisbury</i>				b. COUNTY <i>Decomac</i>							
c. LENGTH OF STAY IN 1b <i>1 week</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Oak Hall Inn</i>							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Peninsula General Hospital</i>				d. STREET ADDRESS <i>U. S. 13</i>							
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
3. NAME OF DECEASED (Type or print)		First <i>John</i>		Middle <i></i>		Lost <i>Bull</i>		4. DATE OF DEATH <i>July 9 1958</i>		Month Day Year	
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>APR 27 1976</i>		9. AGE (In years last birthday) <i>32 yrs.</i>		IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Septor of Church</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Sexton</i>		11. BIRTHPLACE (State or foreign country) <i>Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		IF UNDER 24 HRS Hours Min			
13. FATHER'S NAME <i>GEORGE</i>		14. MOTHER'S MAIDEN NAME <i>TABITHA BACON</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>128-43-744</i>		17. INFORMANT <i>C. Ball</i>		Address <i>Oak Hall Inn</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CORONARY THROMBOSIS</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) _____ DUE TO (c) _____											
INTERVAL BETWEEN ONSET AND DEATH <i>10 mins</i>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>INGUINAL HERNIA - INCARCERATED (LEFT)</i>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour o. m. <i>19</i> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from <i>6-30</i> , 19 <i>58</i> , to <i>7-9</i> , 19 <i>58</i> that I last saw the deceased alive on <i>7-9</i> , 19 <i>58</i> , and that death occurred at <i>11:30 AM</i> , from the causes and on the date stated above.											
ADDRESS (Street, city or town, state) <i></i>											
DATE SIGNED <i>July 10, 1958</i>											
ACTUAL SIGNATURE <i>John M. Bloxom III</i>		M.D., Medical Certif									
PHYSICIAN'S NAME (Type) <i>JOHN M. BLOXOM III</i>		Salisbury, Maryland									
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Buried</i>		22b. DATE THEREOF <i>July 14, 1958</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Douglas</i>		22d. LOCATION (City, town, or county) <i>Oak Hall Inn</i>		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <i>James N. Fay</i>		ADDRESS <i>Temperanceville</i>		24a. REC'D BY REGISTRAR <i>JUL 17 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Autobeach</i>					



• 9. 44
5

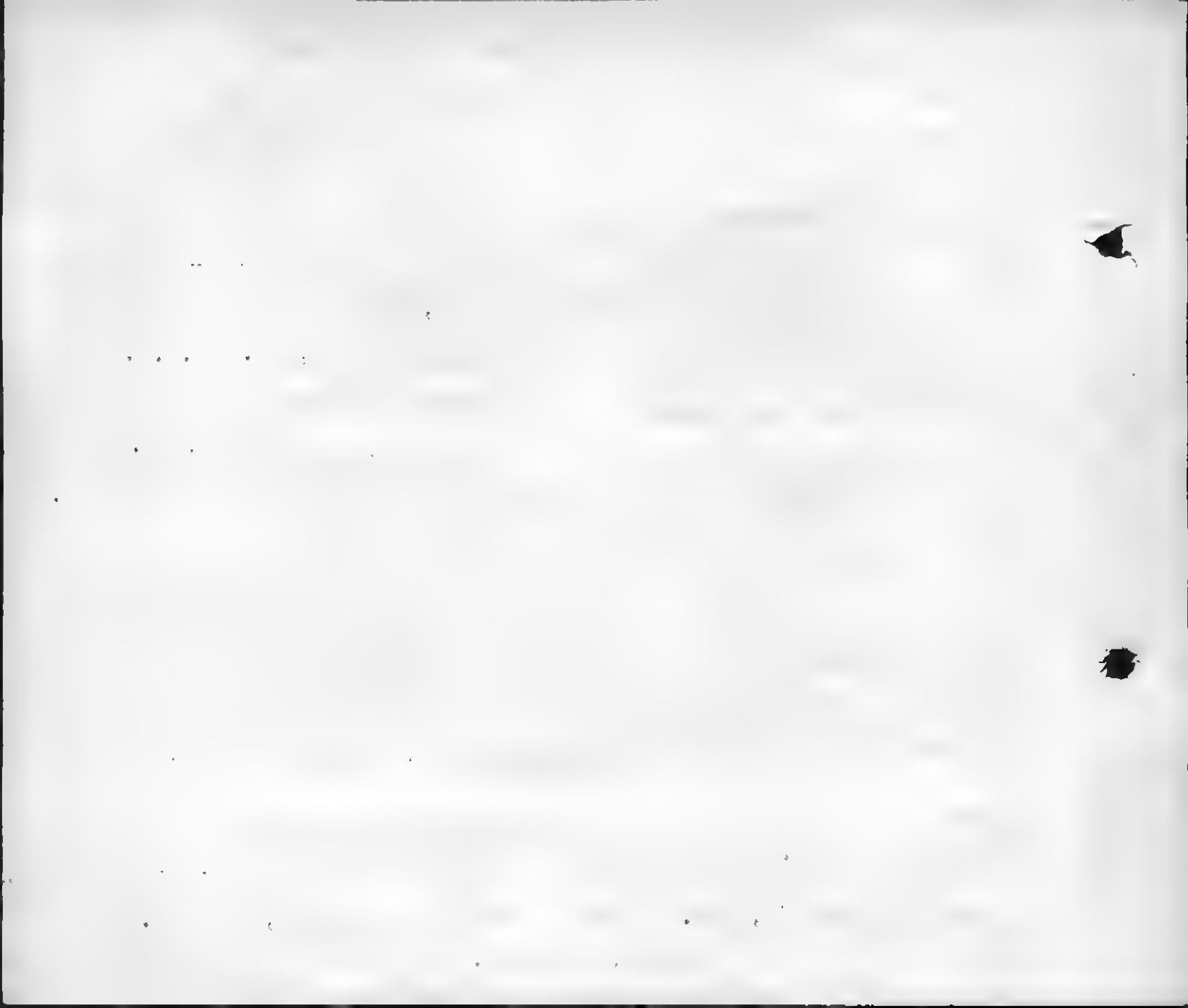
08503

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the words "Pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-trust permit. File pages 1 and 2 with the Board of Health, or its Designated Agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

8500		Reg. Dist. No.	
1. PLACE OF DEATH a. COUNTY Wicomico		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) b. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN lb d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital	
3. NAME OF DECEASED (Type or print) Annie		4. DATE OF DEATH Year 7-22-58	
5. SEX F	6. COLOR OR RACE G	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 12, 1903
9. AGE (In years last birthday) Months 55 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maid		10b. KIND OF BUSINESS OR INDUSTRY Hotel	
10c. BIRTHPLACE (State or foreign country) Accomack County, Va.		11. IF UNDER 24 HRS Hours Min.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME John Miles	
14. MOTHER'S MAIDEN NAME Bessie Drummond		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (For, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT George Miles, Onancock, Va.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 454X		Address	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		INTERVAL BETWEEN ONSET AND DEATH Sudden.	
(b) DUE TO Left iliac thrombosis		24 hours	
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Earl L. Royer</i> EXAMINER'S NAME (Type) Earl L. Royer, M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 7-22-58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 27, 1958.	
22c. NAME OF CEMETERY OR CREMATORIUM Joynes Cemetery		22d. LOCATION (City, town, or county) Onancock, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. Edgar Thomas, Accomac, Virginia.</i>		24a. REC'D BY REGISTRAR DATE JUL 28 '58 24b. REGISTRAR'S SIGNATURE <i>Debrauch</i>	
VS. A15ME SM 2/57			



MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

115504

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Ky		Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN lb 7 months		b. COUNTY Wicomico		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 308 East Church St.		d. STREET ADDRESS 308 East Church St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Samuel	Middle 	Last Butler Jr.	4. DATE OF DEATH	Month 7	Day 24	Year 1958
5. SEX Male	6. COLOR OR RACE AA	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 1-27-1957	9. AGE (In years last birthday) 1 yrs.	IF UNDER 1 YEAR Months 6	IF UNDER 24 HRS Days 26	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Samuel Butler, Sr.				14. MOTHER'S MAIDEN NAME Idaree Brand			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mr. Samuel Butler, Sr., Salisbury, Md.		Address 308 East Church St., Salisbury, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) NEVER DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO Macrocephalus Possible Injury at Birth Epilepsy INTERVAL BETWEEN ONSET AND DEATH 1 day 13 months PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION Obesity Was autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No [2]							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.) Salisbury Wicomico Md	20f. (City or town) Salisbury	(County) Wicomico	(State) Md	
21. I certify that I attended the deceased from January 15, 1958 , to July 24, 1958 , that I last saw the deceased alive on July 23, 1958 , and that death occurred at 5:30 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE G. Herbert Sembley ADDRESS (Street, city or town, state) Dr. Herbert G. Sembley, 400 East Church St., Salisbury, Md. DATE SIGNED 7/24/58							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-25-1958	22c. NAME OF CEMETERY OR CREMATORIUM Mt. Calvary Cemetery	22d. LOCATION (City, town, or county) Fruitland, Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE J. F. Stewart Funeral Home, Salisbury, Md.				ADDRESS	24a. REC'D BY REGISTRAR Jul 31 '58	24b. REGISTRAR'S SIGNATURE Albert French	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this cert. has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as a burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08505

8502

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland		b. COUNTY Worcester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN lb 372 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bishop			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Jennie		First E.	Middle Campbell	Last July	DATE OF DEATH 23	Month 1958	Day Year
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 6, 1870	9. AGE (In years last birthday) 87 yrs.	IF UNDER 1 YEAR Months 0		IF UNDER 24 HRS Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PETI RGP		10b. KIND OF BUSINESS OR INDUSTRY HOUSEWIFE		11. BIRTHPLACE (State or foreign country) Delaware		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph M. Croes		14. MOTHER'S MAIDEN NAME Annie Swaney		Address Salisbury, Maryland			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk		16. SOCIAL SECURITY NO. No		17. INFORMANT Hospital Records,			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 52.9X		DUE TO Hypostatic Pneumonia		INTERVAL BETWEEN ONSET AND DEATH 5 days			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Hypertensive Arteriosclerotic Cardiovascular Disease; Paralysis agitans							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County)	(State)	
21. I certify that I attended the deceased from July 16 , 1957, to July 23 , 1958, that I last saw the deceased alive on July 23 , 1958, and that death occurred at 4:50 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Deer's Head State Hospital DATE SIGNED 7/24/58							
ACTUAL SIGNATURE <i>G. Kosmahl</i>		PHYSICIAN'S NAME (Type) G. Kosmahl, M. D.		Salisbury, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 7/26/58	22c. NAME OF CEMETERY OR CREMATORIAL ODD Fours	22d. LOCATION (City, town, or county) BISHOPVILLE		(State) MD		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Anna A. Burbage Berlin Md.</i>		ADDRESS ADDRESS	24a. REC'D BY REGISTRAR DATE JUL 28 '58		24b. REGISTRAR'S SIGNATURE <i>W. L. Smith</i>		



1

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the words "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMA3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MS A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										08508			
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										Reg. Dist. No.			
8503 Items 4, 9 Film G 231 7/12/58 pg 1													
1. PLACE OF DEATH		a. COUNTY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN TB		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)		b. COUNTY			
Wicomico		MARYLAND		Salisbury		Life		Maryland		Wicomico			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		Home		d. STREET ADDRESS		Salisbury		612 W. Main St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First		Middle		4. DATE OF DEATH		Month		Day Year			
Agnes		Collins		er		6-7		6		8- 1958			
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH		9. AGE (in years JUL birthday)		IF UNDER 1 YEAR IF UNDER 24 HRS			
Female		Cal		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Feb 17 - 1886		11 2 yrs		Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?							
Housewife		None		Baltimore Md		U.S.A							
13. FATHER'S NAME		?		14. MOTHER'S MARRIED NAME		Rebecca Collins							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO		17. INFORMANT		Address							
(Item no. or unknown)		None		Beatrice Broder									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]													
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Coronary Occlusion											
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		Arterio-sclerotic heart disease											
(b)		Yes											
(c)													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)													
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)			
19													
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <i>Earl L. Roger</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 7-12-58									
EXAMINER'S NAME (Type) <i>Earl L. Roger</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>											
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial 7-58</i>		22b. DATE THEREOF <i>7-58</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Green Acres</i>		22d. LOCATION (City, town, or county) <i>Rockaway Md</i>		(State)					
23. FUNERAL DIRECTOR'S SIGNATURE <i>Booker W. Cook</i>		ADDRESS		24a. REC'D BY REGISTRAR <i>Jul 15 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Alvarez</i>							



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

08507

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page may be reigned by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this cert. has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use of the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Micromedical</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE DELAWARE		b. COUNTY SUSSEX	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Salem</i>		c. LENGTH OF STAY IN 1b <i>14 hrs.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GUMBORO			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Connivita General Hospital</i>		d. STREET ADDRESS <i>WILLARDS, I.D. R.F.D.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>Arthur</i>	Middle <i>B</i>	Last <i>Collins</i>	4. DATE OF DEATH <i>July 13</i>	Month <i>July</i>	Day <i>13</i>	Year <i>1958</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <i>DEC. 5, 1899</i>	9. AGE (In years last birthday) <i>58 yrs</i>	IF UNDER 1 YEAR Months <i>0</i>	IF UNDER 24 HRS Days <i>0</i>	Hours <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MERCHANT & FARMING		10b. KIND OF BUSINESS OR INDUSTRY SELF		11. BIRTHPLACE (State or foreign country) DELAWARE		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME NOAH J. COLLINS		14. MOTHER'S MAIDEN NAME DELLA H. COLLINS		Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i>		16. SOCIAL SECURITY NO <i>118-34-9520</i>		17. INFORMANT <i>R. V. GARDNER, WILLARDS, MD. R.F.D.</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cerebrovascular accident</i>	
440X		DUE TO <i>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last</i>		(b) <i>Hypertension</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i>	
DUE TO <i>(c)</i>		<i>Cerebrovascular disease</i>		<i>Acute, lens of breakdown (uremia)</i>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>2 days</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b) <i>From the causes and on the date stated above.</i>		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>7/14 1958</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>PINEBLUFF Rd.</i>	
20f. (City or town) <i>Salisbury</i>		(County) <i>WILLARDS, MD.</i>		(State) <i>MARYLAND</i>		21. I certify that I attended the deceased from <i>7/14</i> , 1958, to <i>7/15</i> , 1958, that I last saw the deceased alive on <i>7/14</i> , 1958, and that death occurred at <i>3:30</i> P.M., from the causes and on the date stated above. ACTUAL SIGNATURE <i>Ruthie S. Gardner, Jr.</i>	
21. I certify that I attended the deceased from <i>7/14</i> , 1958, to <i>7/15</i> , 1958, that I last saw the deceased alive on <i>7/14</i> , 1958, and that death occurred at <i>3:30</i> P.M., from the causes and on the date stated above. ACTUAL SIGNATURE <i>Ruthie S. Gardner, Jr.</i>		ADDRESS (Street, city or town, state) <i>PINEBLUFF Rd.</i>		DATE SIGNED <i>7/15/58</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>7/17/58</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Bethel Cemetery</i>		22d. LOCATION (City, town, or county) <i>WILLARDS, MD. R.F.D.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>HOLLYWAY & COMPANY</i>		ADDRESS <i>SALISBURY MARYLAND</i>		24a. REC'D BY REGISTRAR DATE <i>JUL 23 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Alfred couch</i>	



MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

085418

8505

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as a burial-transit permit. Then please remove carbon papers. Page 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
Wicomico				a. STATE	b. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
SALISBURY		3 DAYS		GREENBACKVILLE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PENINSULA GENERAL HOSPITAL					
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH
NELSON		P		Collins	JULY 29 1958
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday) 1678/14 yrs.
MALE		WHITE	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Nov 15 1892	IF UNDER 1 YEAR Months Days Hours Min
10a. US/JAL OCCUPATION (Give kind of work done during most of working life even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Saw wood & dealer own business				Greenbackville, Va.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Peter Collins		Elijah Gatter			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> Yes		16. SOCIAL SECURITY NO.		17. INFORMANT	
(If yes, give rank & date of service)		1330-42-5076		Mrs Mary A. Collins, Greenbackville, Va.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		Address			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>S shock</u>		INTERVAL BETWEEN ONSET AND DEATH 18 Hours			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		DUE TO <u>Cerebralized Peritonitis</u>			
(b)		DUE TO <u>Perforation Colon due to Dissection</u>			
(c)		10 AM			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month Day Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Name, form, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7/26, 1958, to 7/29, 1958, that I last saw the deceased alive on 7/29, 1958, and that death occurred at 10 AM, from the causes and on the date stated above.		ADDRESS (Street, city or town, state)			
ACTUAL SIGNATURE <u>John M. Bloxom III</u>		MEDICAL CENTER, SALISBURY, MD.			
PHYSICIAN'S NAME (Type) <u>JOHN M. BLOXOM III</u>		DATE SIGNED 7/29/58			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. LOCATION (City, town, or county) (State)	
Burial Aug 1/58		Greenbackville County		Greenbackville, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR	
<u>May E. Dennis</u>		Snow Hill, Md.		DATE 28 JUN 58	
				24b. REGISTRAR'S SIGNATURE <u>John E. Smith</u>	

7



10
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08510

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Give pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wiscomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE Maryland b. COUNTY 7-1	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Tyaskin	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		e. IS PERSON ENTITLED ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) George Dashiels		4. DATE OF DEATH 7- 31- 1958	Month Day Year
5. SEX M	6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 12/25/02 55	9. AGE (In years last birthday) Months Days Hours Min 18 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lumber		10b. KIND OF BUSINESS OR INDUSTRY Logging Factory	11. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME Joseph Dashiels		14. MOTHER'S MAIDEN NAME Elizabeth Waters	
15. WAS DECEASED EVER IN U. S. ARMED FORCES (Yes, no, or unknown)		16. SOCIAL SECURITY NO 145-05-0666	17. INFORMANT Linwood Wilson, Tyaskin, Md.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)		Address Sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH,		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Earl L. Royer, M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED 8-1-58			
22a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial		22b. DATE THEREOF 8/3/58	
22c. NAME OF CEMETERY OR CREMATORIUM Mt. W. Town Cem.		22d. LOCATION (City, town, or county) Tyaskin, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE C. P. Messick, Bu. Office, Jr. J. d.		24a. REC'D BY REGISTRAR DATE AUG 5 '58	
ADDRESS		24b. REGISTRAR'S SIGNATURE A. E. Finch	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08511

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o COUNTY Wicomico		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Hebron		c. LENGTH OF STAY IN 1b Lifetime	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS X Hebron (rural)	
f. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First JAMES	Middle ELDRIDGE DENSON	Last L
4. DATE OF DEATH	Month July	Day 12	Year 1958
5. SEX	6. COLOR OR RACE Male	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/9/1876
			9. AGE (In years from birth) 82 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Owner	10c. BIRTHPLACE (State or foreign country) Maryland
11. CITIZEN OF WHAT COUNTRY? U. S.			
13. FATHER'S NAME James Denson		14. MOTHER'S MAIDEN NAME Sallie Street	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) NO		16. SOCIAL SECURITY NO.	17. INFORMANT Bessie Mezick Denson, Hebron, Md. R.F.D.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 week	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>July 12, 1958</u> , to <u>July 12, 1958</u> , that I last saw the deceased alive on <u>July 12, 1958</u> , and that death occurred at <u>6:30 A.M.</u> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Hebron, Maryland	
ACTUAL SIGNATURE William Emrich		DATE SIGNED 7/14/58	
PHYSICIAN'S NAME (Type) William Emrich		Hebron, Maryland 7/14/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/15/58	22c. NAME OF CEMETERY OR CREMATORIUM Denson family cem.
22d. LOCATION (City, town, or county) Clara, Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE C. St. Mezick, Bivalve, Maryland		24a. RECEIVED BY REGISTRAR JUL 25 1958	24b. REGISTRAR'S SIGNATURE A. J. Mezick
ADDRESS Bivalve, Maryland		DATE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as a burial-transit permit. Then please remove carbon papers. Page 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8507 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

08512

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Farm PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the state Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Wicomico	MARYLAND	2. USUAL RESIDENCE (Where deceased lived if institution, residence before admission) a. STATE New Jersey	b. COUNTY Hudson			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	c. LENGTH OF STAY IN 1b Peninsula General Hospital	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bayonne	d. STREET ADDRESS 67 X - 5			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RES. DEN. ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Mary Josephine Donovan	First	Middle	DATE OF DEATH Month Day Year 7-2-1958			
4. SEX F	5. COLOR OR RACE W	6. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 7. WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 26, 1921			
9. AGE (In years from birthday) 36 yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary - U.S. Navy Dept. Depot		11. BIRTHPLACE (State or foreign country) Newark, New Jersey				
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Martin Davey				
14. MOTHER'S MAIDEN NAME Mary Noon		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk				
16. SOCIAL SECURITY NO. (If yes, give year or date of service)		17. INFORMANT Mr. William Henry Donovan (Husband) Bayonne New Jersey				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))						
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aspiration of vomitus DUE TO 25X						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pulmonary atelectasis DUE TO (c) Multiple contusions and lacerations of DUE TO						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH WHICH RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> OF CAUSE OF DEATH.				
20a. TIME OF INJURY Month, Day, Year 11:50 AM 6-30-58		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18) Injured in accident while passenger in front seat.	20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. (City or town) Princess Anne Somerset Md	(County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>						
ACTUAL SIGNATURE <i>Earl L. Royer</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED 7-2-58			
EXAMINER'S NAME (Type) Earl L. Royer, M.D.		22a. BURIAL CREMATION, REMOVAL (Specify) Burial July 5, 1958	22b. DATE THEREOF July 5, 1958	22c. NAME OF CEMETERY OR CREMATORIUM St. Mary's Cemetery	22d. LOCATION (City, town, or county) East Orange, New Jersey	(State)
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		ADDRESS SALISBURY MARYLAND	24a. REC'D BY REGISTRAR JUL 7 '58	24b. REGISTRAR'S SIGNATURE <i>Quinton</i>		



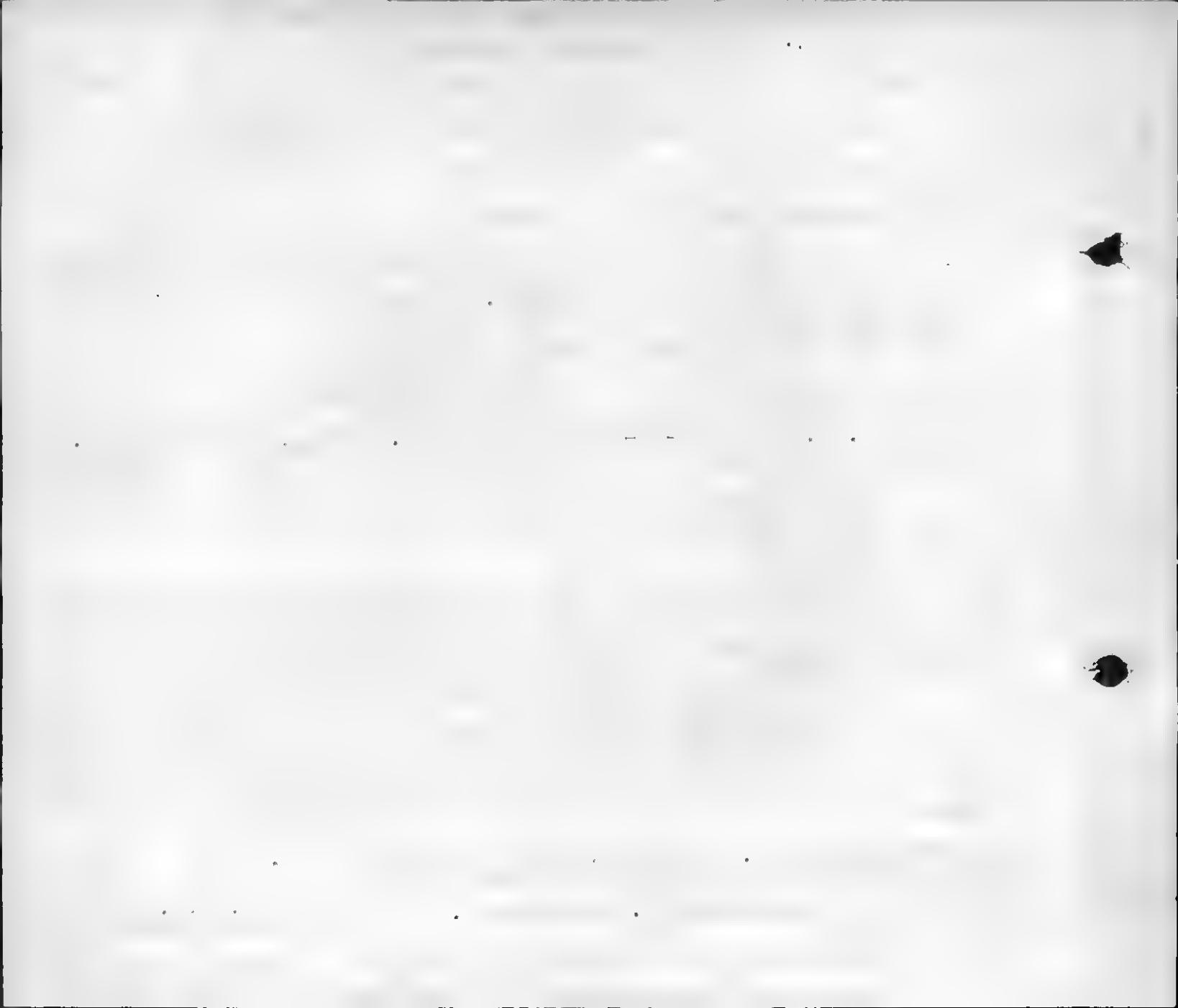
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use of a burial-transit permit. Then please remove carbon papers. Page 3 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8508 CERTIFICATE OF DEATH

Reg. Dist. No. 05513

1. PLACE OF DEATH a. COUNTY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE NEW JERSEY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SALISBURY		c. LENGTH OF STAY IN 1b RURAL and give nearest town CUMAIRLAND				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION PENINSULA GENERAL HOSPITAL		e. STREET ADDRESS 78 SOUTH EAST AVE.				
3. NAME OF DECEASED (Type or print) FRANK WILLIAM		4. DATE OF DEATH JULY 4 1958				
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 8, 1923			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Inspector		10b. KIND OF BUSINESS OR INDUSTRY Glass Industry	11. BIRTHPLACE (State or foreign country) Bridgeton, N.J.			
13. FATHER'S NAME William Estlow		14. MOTHER'S MAIDEN NAME Adeline Stubbs				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO W. W. II 154-18-8595	17. INFORMANT Victoria H. Estlow, Bridgeton, N.J.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial Infarct, acute		INTERVAL BETWEEN ONSET AND DEATH 1 day				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO 720.1 (b) DUE TO (c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) St. Mary's Cemetery	20f. (City or town) Bridgeton	(County) Atlantic	(State) N.J.
21. I certify that I attended the deceased from 7-3 , 19 58 , to 7-4 , 19 58 , that I last saw the deceased alive on 7-4 , 19 58 , and that death occurred at 1210 P.M. , from the causes and on the date stated above.						
ACTUAL SIGNATURE William R. Ellis, Jr., M.D.				ADDRESS (Street, city or town, state) Takesleevy, Md.		
DATE SIGNED 7-4-58						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 7, 1958	22c. NAME OF CEMETERY OR CREMATORIUM St. Mary's Cemetery	22d. LOCATION (City, town, or county) Bridgeton, N.J.		
23. FUNERAL DIRECTOR'S SIGNATURE Hill Johnson SALISBURY, Md.		ADDRESS Tommon F. Baker	24a. REC'D BY REGISTRAR DATE JUL 8 1958	24b. REGISTRAR'S SIGNATURE W. L. ELLIS		



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8549 CERTIFICATE OF DEATH

08514

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY Wicomico				2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mardela Springs				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mardela Springs				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Maple Shade Convalescent Home				d. STREET ADDRESS Bridge				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3 NAME OF DECEASED (Type or print)		First Sadie	Middle Maria	Last Eversman	4. DATE OF DEATH July 14	Month July	Day 14	Year 1958
5 SEX Female		6. COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH April 19, 1878	9. AGE (In years last birthday) 80 yrs	IF UNDER 1 YEAR Months 80	IF UNDER 24 HRS Days 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY USA		
13. FATHER'S NAME William Denohu				14. MOTHER'S MAIDEN NAME Emily Austin				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO None		17. INFORMANT J. Ware Eversman, Mardela Springs, Md.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio Renal Myocarditis DUE TO 44dx Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
INTERVAL BETWEEN ONSET AND DEATH 10 years								
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
MEDICAL CERTIFICATION								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from July 14 , 1958, to July 14 , 1958, that I last saw the deceased alive on July 14 , 1958, and that death occurred at 6 P.M. from the causes and on the date stated above.								
ACTUAL SIGNATURE H.S. Kublman				ADDRESS (Street, city, town, state) Sharplawn Rd., Sharplawn, Md.				
PHYSICIAN'S NAME (Type) H.S. Kublman		DATE SIGNED 7/15/58						
22a. BURIAL, CREMATON, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-17-58		22c. NAME OF CEMETERY OR CREMATORIUM Emanuel Methodist		22d. LOCATION (City, town, or county) (State) Mardela Springs, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE Charles W. Jarrel, Shapley, Md.		ADDRESS 111 W. Main St., Shapley, Md.		24a. REC'D BY REGISTRAR DATE Jul 17 1958		24b. REGISTRAR'S SIGNATURE Charles W. Jarrel		



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8509

CERTIFICATE OF DEATH

08515

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WICOMICO		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE DELAWARE		b. COUNTY SUSSEX							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SALISBURY		c. LENGTH OF STAY IN lb 30 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BLADES									
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION PENINSULA GENERAL HOSPITAL		d. STREET ADDRESS 101 E. HIGH ST.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print)	First ORA	Middle PAGE	Last FLEETWOOD	4. DATE OF DEATH JULY 21 1958	Month JULY	Day 21	Year 1958						
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH JAN 16, 1900	9. AGE (In years last birthday) 58 yrs	E. UNDER 1 YEAR IF UNDER 24 HRS. Months 5	Days 8	Hours 0						
8. OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) DELAWARE		12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME ISAAC E. ELLIOTT		14. MOTHER'S MAIDEN NAME MARY JANE PRETTYMAN		Address									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO		16. SOCIAL SECURITY NO —		17. INFORMANT HARRY B FLEETWOOD - BLADES, DEL.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (d) Congestive heart failure, 1 yr. Arteriosclerotic Heart Disease													
INTERVAL BETWEEN ONSET AND DEATH													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) —											
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —		20f. (City or town) (County) (State) —							
21. I certify that I attended the deceased from July 21, 1958 to July 21, 1958 , that I last saw the deceased alive on July 21, 1958 ; and that death occurred after July 21, 1958 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Blades, Del. DATE SIGNED July 21, 1958													
ACTUAL SIGNATURE David J. Gilmore													
PHYSICIAN'S NAME (Type) David J. Gilmore		22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL JUL 24, 1958						22b. DATE THEREOF BLADES CEMETERY		22c. NAME OF CEMETERY OR CREMATORIAL BLADES CEMETERY		22d. LOCATION (City, town, or county) (State) BLADES, DELAWARE	
23. FUNERAL DIRECTOR'S SIGNATURE Malvold L. Watson Jr. - SEAFORD, DEL.		ADDRESS Seaford, Del.		24a. REC'D. BY REGISTRAR JUL 23		24b. REGISTRAR'S SIGNATURE Malvold L. Watson Jr. - Seaford, Del.							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 should be detached for use on the burial permit. Then please remove carbon paper. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon paper. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as a burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8510 CERTIFICATE OF DEATH

08516

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury, Maryland		c. LENGTH OF STAY IN lb 12 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital				d. STREET ADDRESS 303 S. Washington Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First Ruth	Middle Virginia	Last Gibson	4. DATE OF DEATH July	Month 12	Year 1958
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 17, 1894		9. AGE (In years last birthday) 63 yrs	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Dots Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unk.		10b. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unk. John Watson		14. MOTHER'S MAIDEN NAME Mary Nickie					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO Unknown		17. INFORMANT Hospital Records		Address Salisbury	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 331X		Hypostatic Pneumonia				INTERVAL BETWEEN ONSET AND DEATH 2 days	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b)		Quadriplegia after C.V.A.				4½ mos.	
(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> or work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
19		While of work <input type="checkbox"/> or work <input type="checkbox"/>					
21. I certify that I attended the deceased from June 30, 1958, to July 12, 1958, that I last saw the deceased alive on July 12, 1958, and that death occurred at 4 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Dr. Gerhard Kosmahl M.D.							
DATE SIGNED 7-12-58							
ACTUAL SIGNATURE <i>Dr. Kosmahl</i>							
PHYSICIAN'S NAME (Type) Deer's Head State Hospital, Salisbury, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) 7/12/58		22b. DATE THEREOF 7/12/58		22c. NAME OF CEMETERY OR CREMATORIUM St. Marks		22d. LOCATION (City, town, or county) Lancaster, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Conway Jr. & Son. Funeral Home</i>		ADDRESS 100 W. Main St., Lancaster, Md.		24a. REC'D BY REGISTRAR DATE JUL 15 '58		24b. REGISTRAR'S SIGNATURE Ollie L. French	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as a burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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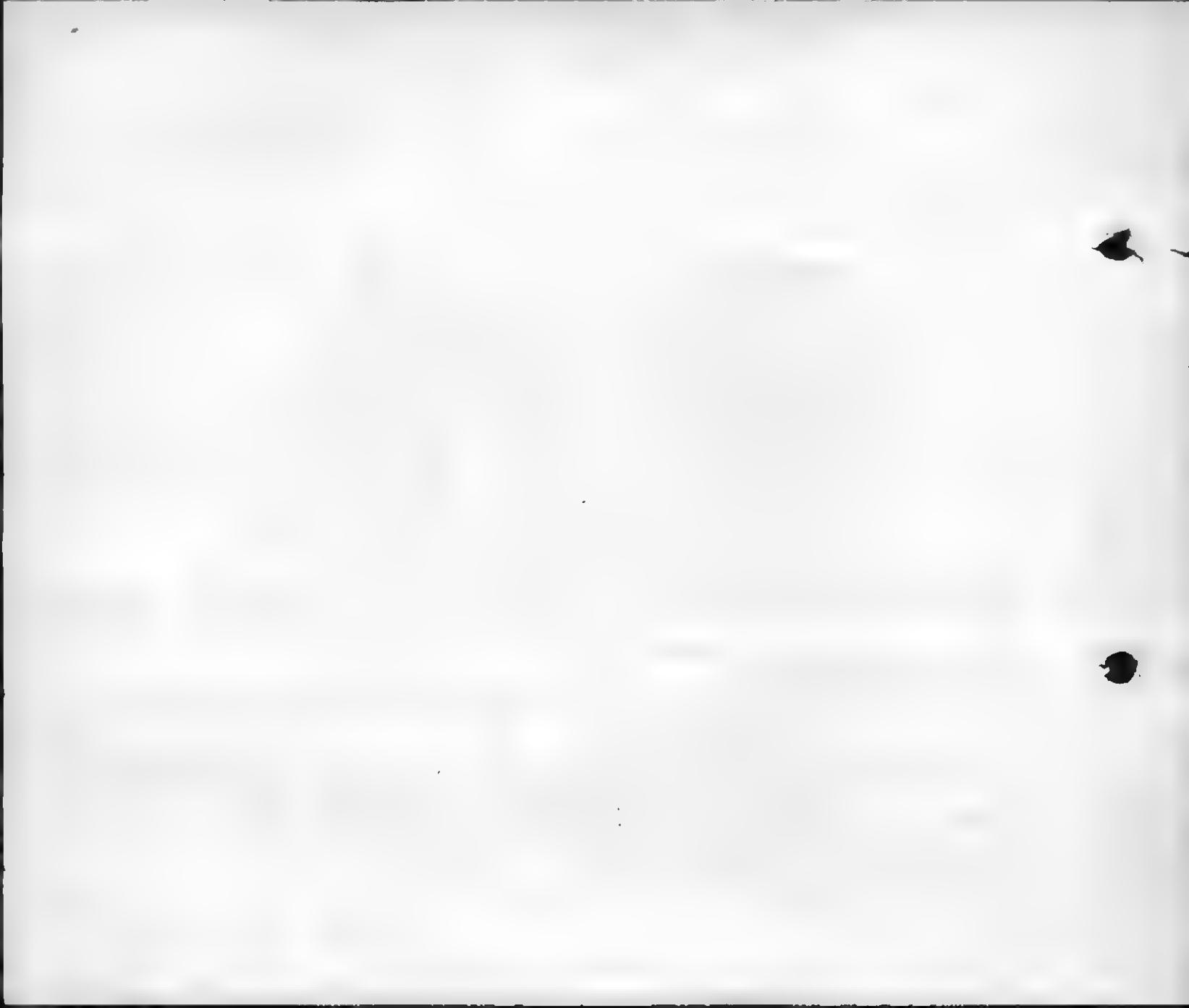
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8511 CERTIFICATE OF DEATH

08517

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Princess Anne</i>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Princess Anne</i>		d. STREET ADDRESS <i>Princess Anne</i>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Perkins General Hospital</i>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <i>Baby</i>		First	Middle	Last	4. DATE OF DEATH <i>July 14</i>	Month	Day	Year <i>1958</i>		
5. SEX <i>Female</i>		6. COLOR OR RACE <i>Negro</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>7/13/58</i>		9. AGE (In years last birthday) yrs. <i>1</i>	10. IF UNDER 1 YEAR Months <i>3</i>	11. IF UNDER 24 HRS Days <i>3</i>	Hours <i>0</i>	Min <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY?				
13. FATHER'S NAME <i>James Hall</i>		14. MOTHER'S MAIDEN NAME <i>Neoma Mason</i>								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) (If yes, give war or date of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Marthy Hall Princess Anne</i>		Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Atelectasis</i>						INTERVAL BETWEEN ONSET AND DEATH				
162.5 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)		DUE TO 162.5 Due to (c)		Prematurity (1350 gms)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Salisbury, Md.</i>		20f. (City or town) <i>Salisbury</i>		(County) <i>Md.</i>		(State) <i>Md.</i>
21. I certify that I attended the deceased from <i>7/13/58</i> to <i>7/17/58</i> , and that I last saw the deceased alive on <i>7/14/58</i> , and that death occurred at <i>3:15 PM</i> , from the causes and on the date stated above. ACTUAL SIGNATURE <i>Ayleen C. Kolls, M.D.</i>						ADDRESS (Street, city or town, state) <i>Medical Center</i>				
PHYSICIAN'S NAME (Type) <i>Medical Center</i>						DATE SIGNED <i>7/14/68</i>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>7/14/58</i>		22c. NAME OF CEMETERY OR CEMETORY <i>St. Mark</i>		22d. LOCATION (City, town, or county) <i>Oakville</i>		(State) <i>Md.</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>William H. James Jr., Princess Anne</i>		ADDRESS				24a. REC'D BY REGISTRAR DATE <i>JUL 15 '58</i>		24b. REGISTRAR'S SIGNATURE <i>W. L. couch</i>		



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8550

CERTIFICATE OF DEATH

08518

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Wicomico		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Delmar		c. LENGTH OF STAY IN 1b 15 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Delmar				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R. R. # 3				d. STREET ADDRESS R. R. # 3		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) WILLIAM		First	Middle	Last	4. DATE OF DEATH July 23	Month	Day	Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH Dec. 27, 1882	9. AGE (In years lost birthday) 75 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
8. OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Carpenter		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Delaware		12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME William Burton H. Milton		14. MOTHER'S MAIDEN NAME Rebecca Spear						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 95-05-7705A		17. INFORMANT Mrs. Sarah J. Anderson, Delmar, Del.		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Severe cardiac failure		INTERVAL BETWEEN ONSET AND DEATH July 27				
		DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.	(b) Hypertension Cardio Vascular Disease	DUE TO 2 yrs	(c)			
19. MEDICAL CERTIFICATION		Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)						
20c. TIME OF INJURY Hour a. p. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Nat white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Delmar		(County) Del. (State) Del.
21. I certify that I attended the deceased from July 27, 1958 to July 28, 1958 that I last saw the deceased alive on July 27, 1958 , and that death occurred at Delmar, Del. M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Delmar, Del.		DATE SIGNED July 29, 1958				
ACTUAL SIGNATURE S. H. Lynch		M.D.						
PHYSICIAN'S NAME (Type) S. H. Lynch								
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 7-21-1958		22c. NAME OF CEMETERY OR CREMATORIAL Hollywood		22d. LOCATION (City, town, or county) Harrison, Del.		(State)
23. FUNERAL DIRECTOR'S SIGNATURE Mrs. S. H. Boyer, Harrington, Del.		ADDRESS		24a. REC'D BY REGISTRAR DATE 7 '58		24b. REGISTRAR'S SIGNATURE Delmar		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO DUTY MEDICAL DIRECTOR: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, removal, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8512 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08519

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Wicomico</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Md</i>		b. COUNTY <i>Wicomico</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Salisbury</i>		c. LENGTH OF STAY IN 1b <i>1</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Salisbury, Md.</i>		d. STREET ADDRESS <i>—</i>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>—</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <i>John</i>		First <i>John</i>	Middle <i>Hammond</i>	Last <i>John</i>	4. DATE OF DEATH <i>7-20-58</i>	Month <i>7</i>	Day <i>20</i>	Year <i>1958</i>
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>2-12-14</i>	9. AGE (in years less birthday) <i>54 yrs.</i>	10. IF UNDER 1 YEAR Months <i>—</i>	11. IF UNDER 24 HRS. Days <i>—</i>	12. IF UNDER 24 HRS. Hours <i>—</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Labor</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Labor</i>		11. BIRTHPLACE (State or foreign country) <i>Pa</i>		12. CITIZEN OF WHAT COUNTRY? <i>Salisbury Police Dept.</i>		
13. FATHER'S NAME <i>John</i>		14. MOTHER'S MAIDEN NAME <i>Stetler</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>—</i>		
17. INFORMANT <i>Salisbury Police Dept.</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Accidental drowning</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <i>10 mins</i>		
20. MEDICAL CERTIFICATION		Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>(b)</i> DUE TO <i>—</i> (c) DUE TO <i>—</i>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Fell in river while fishing from bridge</i>				
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <i>Fell in river while fishing from bridge</i>		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>July 20 1958</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> <i>At home</i>		20e. PLACE OF INJURY (Home, farm, office, bldg., etc.) <i>At home</i>
				20f. (City or town) <i>Salisbury, Wicomico, Md.</i>		(County) <i>—</i>		(State) <i>Md</i>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .		ACTUAL SIGNATURE <i>Philip A. Insley</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <i>7-21-58</i>		
EXAMINER'S NAME (Type) <i>Philip A. Insley</i>		22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>7-24-58</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Mt. Calvary</i>		22d. LOCATION (City, town, or county) <i>Baltimore, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Booker Williams</i>		ADDRESS <i>—</i>		24a. REC'D BY REGISTRAR DATE <i>JUL 29 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Out care</i>		



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8513 CERTIFICATE OF DEATH

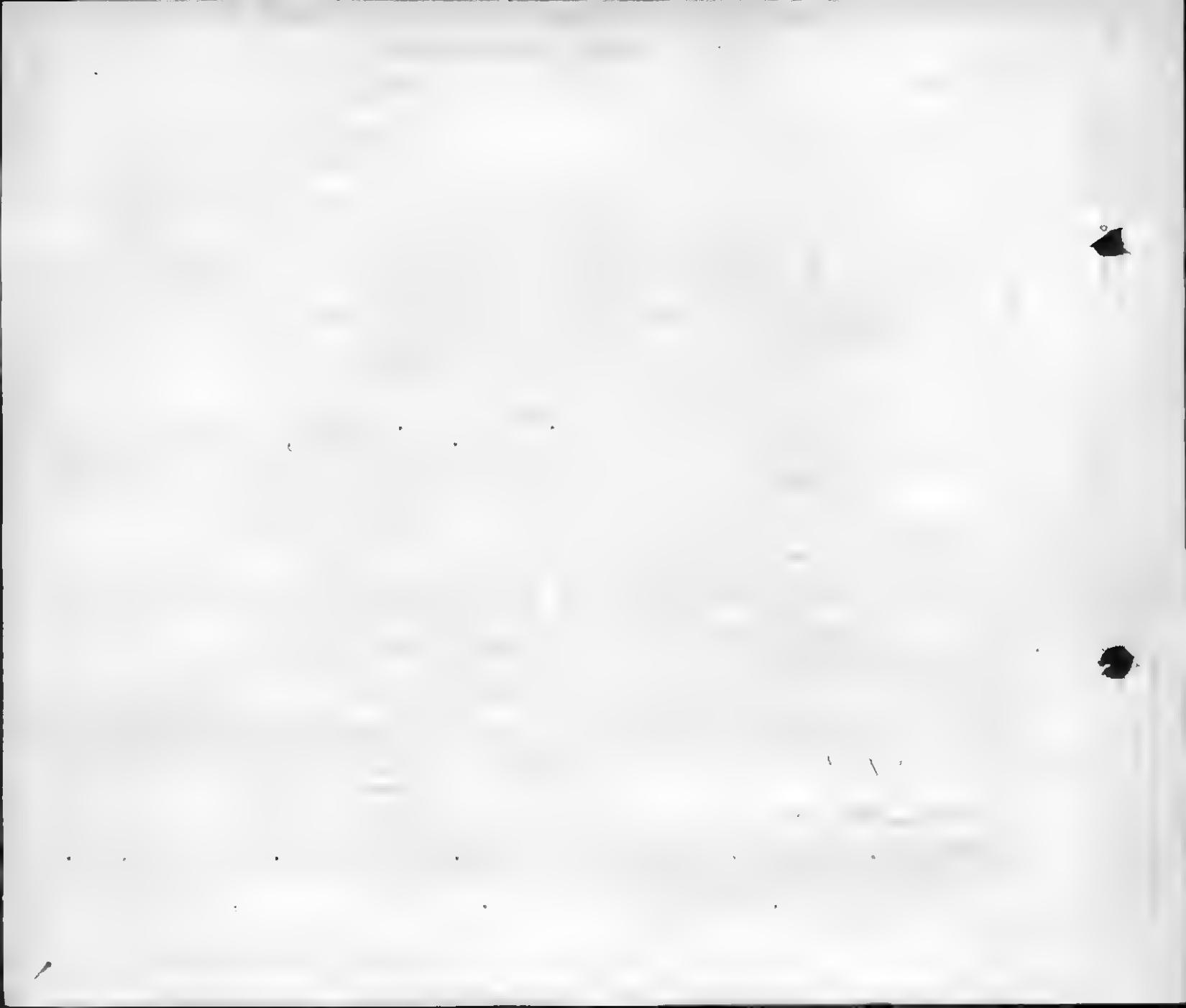
08520

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Riverside Nursing Home		e. STREET ADDRESS Pemberton Drive	
3. NAME OF DECEASED (Type or print) Elizabeth		First Middle Last Emma Hoover	4. DATE OF DEATH July 7th 1958
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 16, 1884
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None-House Work		10b. KIND OF BUSINESS OR INDUSTRY None	9. AGE (In years last birthday) 74 yrs. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.
13. FATHER'S NAME Joseph Orebough		14. MOTHER'S MAIDEN NAME Sarah Hendgardner	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) Unk		16. SOCIAL SECURITY NO.	17. INFORMANT Mr. William S. Hoover (Husband) Address Pemberton Drive. Salisbury, Maryland
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 331X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		INTERVAL BETWEEN ONSET AND DEATH Cardiac Failure - in Hypertensive Heart (b) Cerebral Hemorrhage (3 attacks) (c) Hypertension & Arterio sclerosis	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>April 1, 1958</u> to <u>July 7, 1958</u> , that I last saw the deceased alive on <u>7/7/58</u> , 19 <u>58</u> , and that death occurred at <u>3:10 A.M.</u> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) M.D. 226 N. Division July 8 1958 DATE SIGNED	
ACTUAL SIGNATURE <u>Carrie I. Hearn</u>		PHYSICIAN'S NAME (Type) Dr. Carrie I. Hearn 226 N. Division St. Salisbury, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF July 9, 1958	22c. NAME OF CEMETERY OR CREMATORIUM Spring Hill Mem. Gardens - Easton, Maryland	22d. LOCATION (City, town or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE HOITOWAY & COMPANY		ADDRESS SALISBURY MARYLAND	24a. REC'D BY REGISTRAR DATE JUL 9 '58
			24b. REGISTRAR'S SIGNATURE <u>Abel Lewis</u>

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as a burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death - Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as a burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										Reg. Dist. No. 08521	
8514 CERTIFICATE OF DEATH											
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)						
a. COUNTY Wicomico MARYLAND					b. STATE Maryland b. COUNTY Wicomico						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			c. LENGTH OF STAY IN 1b 13 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hebron						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital					STREET ADDRESS In Village					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED First Harland Middle Hopkins					4. DATE OF DEATH Month July Day 28 Year 1958						
3. SEX Male		6 COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH March 13, 1878		9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer in Lumber Mill-Lumberman		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME John Phillips					14. MOTHER'S NAME Elizabeth Margaret Phillips					Hebron, Maryland	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) Unk					16. SOCIAL SECURITY NO.					17. INFORMANT Mr. Wm T. Hopkins (NeptNew) P.O.B.#226 Hospital Records, Salisbury, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenocarcinoma of the bladder DUE TO ? 151 Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost (b) DUE TO ? (c) DUE TO ?										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from July 16, 1958, to July 28, 1958, that I last saw the deceased alive on July 28, 1958, and that death occurred at 8:10P.M., from the causes and on the date stated above. ACTUAL SIGNATURE G. Kosmahl, M.D. ADDRESS (Street, city or town, state) Deer's Head State Hospital DATE SIGNED 7/29/58											
PHYSICIAN'S NAME (Type) G. Kosmahl, M. D.					Salisbury, Maryland					7/29/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 31, 58		22c. NAME OF CEMETERY OR CREMATORIUM Mardela Cemetery(Old)			22d. LOCATION (City, town, or county) Mardela, Maryland		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY					ADDRESS SALISBURY MARYLAND		24a. REC'D BY REGISTRAR DATE JUL 30 '58		24b. REGISTRAR'S SIGNATURE Allred		



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8515

CERTIFICATE OF DEATH

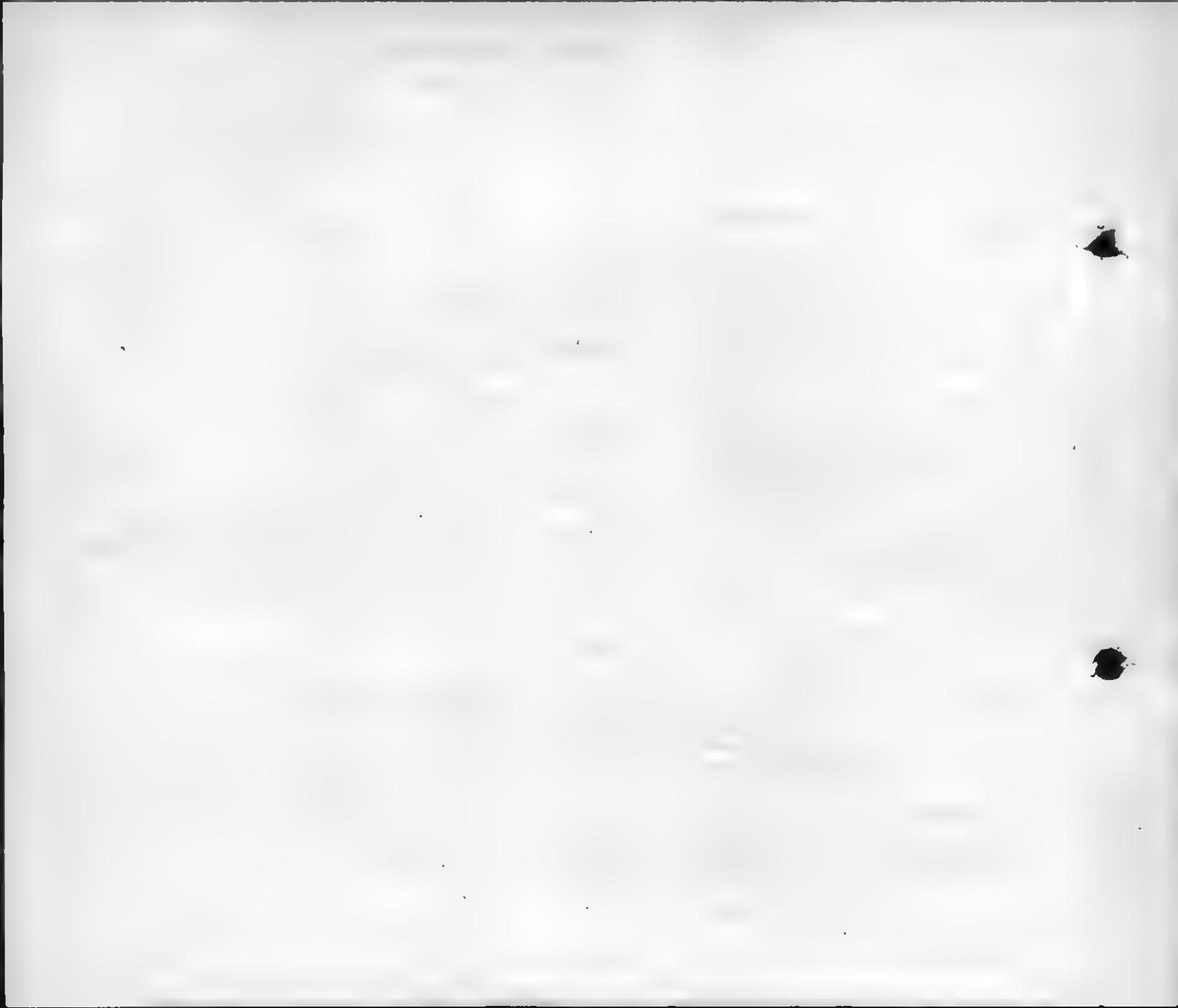
Reg. Dist. No.

08522

1. PLACE OF DEATH a. COUNTY <i>Wicomico</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Delaware</i>		b. COUNTY <i>Sussex</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Salisbury</i>		c. LENGTH OF STAY IN 1b RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>LAUREL</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR-INSTITUTION <i>Peninsula General</i>		d. STREET ADDRESS <i>703 7th Street</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>Mary</i>	Middle <i>Ingersoll</i>	Last <i>Ingersoll</i>	4. DATE OF DEATH <i>July 8</i>	Month <i>July</i>	Day <i>8</i>	Year <i>1958</i>
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>Apr. 4, 1901</i>	9. AGE (in years last birthday) <i>57</i>	IF UNDER 1 YEAR Months <i>0</i>	IF UNDER 24 HRS Days <i>0</i>	Hours <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>own home</i>		11. BIRTHPLACE (State or foreign country) <i>Delaware</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Unknown</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>		Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i>		16. SOCIAL SECURITY NO <i>221-09-5763</i>		17. INFORMANT <i>Stephanie C. Ingersoll, Laurel Del</i>		INTERVAL BETWEEN ONSET AND DEATH <i>unknown</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1.</i> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)		Coronary Artery & Veins Coronary Artery Disease				" "	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Hypertension</i>				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Salisbury</i>	20f. (City or town) <i>Salisbury</i>	(County) <i>Wicomico</i>	(State) <i>Del</i>	
21. I certify that I attended the deceased from <i>July 8</i> , 1958 to <i>July 8</i> , 1958, that I last saw the deceased alive on <i>July 8</i> , 1958, and that death occurred at <i>Salisbury</i> , M.D., from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>Salisbury, Md.</i>		DATE SIGNED <i>July 9, 1958</i>			
ACTUAL SIGNATURE <i>David J. Schlueter</i>		PHYSICIAN'S NAME (Type) <i>David J. Schlueter</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>7/1/58</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Good Fellowship Cemetery</i>	22d. LOCATION (City, town, or county) <i>LAUREL Del</i>	(Note)			
23. FUNERAL DIRECTOR'S SIGNATURE <i>WB Schlueter</i>		ADDRESS <i>Salisbury, Md.</i>	24a. REC'D BY REGISTRAR DATE JUL 11 '58	24b. REGISTRAR'S SIGNATURE <i>WB Schlueter</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as a burial-transit permit. Then please remove carbon paper. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05523

8516 CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use at the funeral home. Then please remove carbon papers. Page 3 and 2 should be filed with the registrar prior to burial, cremation, removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 11/55

1. PLACE OF DEATH a. COUNTY Wicomico		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE MARYLAND		b. COUNTY AnneArundel		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 1 Day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ARNOLD		d. STREET ADDRESS Rugby Hall		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Peninsula General Hospital				d. STREET ADDRESS Rugby Hall		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First mary	Middle Jackson	Lost	4. DATE OF DEATH July 28	Month July	Day 28	Year 1958
S. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Dec. 15, 1911	9. AGE (in years lost birthday) 46 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0	13. IF UNDER 24 HRS. Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME William G. Lehr		14. MOTHER'S MAIDEN NAME Ida 17. Lehr						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no) No		16. SOCIAL SECURITY NO 111222222		17. INFORMANT Albert H. Jackson, Sr.		Address Same As #2		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stoning the under- lying cause lost. (b) DUE TO (c)		Subacute cerebral hemorrhage		1 Day		INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)		20f. (City or town) 7-27, 1958		(County) (State)
21. I certify that I attended the deceased from _____ 7-27, 1958 to _____ 7-28, 1958 that I last saw the deceased alive on _____ 7-28, 1958, and that death occurred at 6:10 P.M. from the causes and on the date stated above.						ADDRESS (Street, city or town, state) 7-28, 1958		DATE SIGNED 7-28, 1958
ACTUAL SIGNATURE Wilber Ellis, Jr.		M.D.		Wilber Ellis, Jr.				
PHYSICIAN'S NAME (Type)		Wilber Ellis, Jr. MEDICAL CENTER						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 1, 1958		22c. NAME OF CEMETERY OR CREMATORIUM Glen Haven		22d. LOCATION (City, town, or county) Glen Burnie, Md.		(State)
23. FUNERAL DIRECTOR'S SIGNATURE B. Washington		ADDRESS Glen Burnie, Md.		24a. REC'D BY REGISTRAR DATE AUG 4 '58		24b. REGISTRAR'S SIGNATURE A. Washington		



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 247 2, 7-25-58 at
8517 CERTIFICATE OF DEATH

06524

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wiscomico MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Wiscomico		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	c. LENGTH OF STAY IN 1b 11 yrs.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury/ Delmar			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION John B. Parsons Home for Aged			d. STREET ADDRESS State Street John B. Parsons Home for Aged		
3. NAME OF DECEASED (Type or print) Fannie Melvin Ker	First	Middle	Last	4. DATE OF DEATH July 17 1958	Month Day Year
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 14, 1880	9. AGE (In years lost birthday) 78 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Practical nurse			10b. KIND OF BUSINESS OR INDUSTRY nursing	11. BIRTHPLACE (State or foreign country) Delaware	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Edward Cannon			14. MOTHER'S MAIDEN NAME Olivia Calleway		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, unknown) No		16. SOCIAL SECURITY NO. No		17. INFORMANT John B. Parsons Home For Aged, Salisbury, Md.	
Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Knee trouble</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <i>Arterio-sclerotic</i> DUE TO (c) <i>Arterio-sclerotic disease</i>					
INTERVAL BETWEEN ONSET AND DEATH					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____, from the causes and on the date stated above.					
ACTUAL SIGNATURE DR. WILLIAM B. SMITH		ADDRESS (Street, city or town, state) The Medical Center Rt. 2, Salisbury Md.		DATE SIGNED 1958	
PHYSICIAN'S NAME (Type) DR. WILLIAM B. SMITH					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/19/1958		22c. NAME OF CEMETERY OR CREMATORIUM Mt. Olive Cemetery	
22d. LOCATION (City, town, or county) Delmar, Delaware		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE Thomas Wallace, Salisbury, Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE JUL 21 '58	
				24b. REGISTRAR'S SIGNATURE Albert J. Smith	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as a burial-transit permit. Then please remove carbon paper. Page 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8518

CERTIFICATE OF DEATH

05525

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico		MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland		b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN lb 3 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Peninsula General Hospital		d. STREET ADDRESS Carolyn Ave.,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First JOHN	Middle ANTHONY	Last KLIEM	4. DATE OF DEATH 7 15 1958	Month 7	Day 15	Year 1958
5. SEX Male	6 COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH May 18, 1907	9. AGE (In years from birthday) 51 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Saleman		10b. KIND OF BUSINESS OR INDUSTRY Electrolux		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frank J. Kliem		14. MOTHER'S MAIDEN NAME Katherine Bormann		Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-09-0637		17. INFORMANT Mrs. Mildred D. Kliem, Same			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) COARCTATION THROMBOSIS INTERVAL BETWEEN ONSET AND DEATH 5 HAS							
DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DIVERTICULUM DUODENUM UNDETERMINED							
DUE TO							
(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7-12 , 1958, to 7-15 , 1958, that I last saw the deceased alive on 7-15 , 1958, and that death occurred at 4:15 A.M. from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)							
ACTUAL SIGNATURE <i>John M. Bloxom</i>	M.D. Salisbury, Maryland						DATE SIGNED 7/15/58
PHYSICIAN'S NAME (Type) Dr. John M. Bloxom, Medical Center, Salisbury, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/18/1958		22c. NAME OF CEMETERY OR CREMATORIUM Holy Cross Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Mill & Johnson Co., Salisbury, Maryland				ADDRESS DATE JUL 16 '58			
Norman T. Baker				24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE <i>Albrecht</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as a burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8519

CERTIFICATE OF DEATH

08526

Reg. Dist. No.

1. PLACE OF DEATH • COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland b. COUNTY Wicomico				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 310 Locust Terrace		d. STREET ADDRESS 310 Locust Terrace	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) GEORGE RAYMOND LAYFIELD	First Middle Last	4. DATE OF DEATH JULY 27th 1958	Month Day Year			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH August 20, 1881	9. AGE (In years (1st birthday) 76 yrs	10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) R.D. # Salisbury, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Samuel T. Layfield		14. MOTHER'S MAIDEN NAME Martha Farlow				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO		17. INFORMANT Mrs. Ruth M. Layfield (Wife) 310 Locust Terrace Salisbury, Maryland		Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 33IX DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)		Cerebral Hemorrhage				INTERVAL BETWEEN ONSET AND DEATH 1 day
DUE TO cause (c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 7-27-1958 to 7-21-1958, that I last saw the deceased alive on 7-3-1958, and that death occurred at 7:15 P.M., from the causes and on the date stated above.				ADDRESS (Street, city or town, state)		DATE SIGNED
MEDICAL SIGNATURE <i>Lee Lawry</i>		M.D.				
PHYSICIAN'S NAME (Type) Dr. Lee Lawry		Fruitland, Maryland		July 28 1958		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 30/58		22c. NAME OF CEMETERY OR CREMATORIUM Parsons Cemetery		22d. LOCATION (City, town, or county) Salisbury, Maryland (State)
23. FUNERAL DIRECTOR'S SIGNATURE HOTOLAWAY & COMPANY		ADDRESS SALISBURY MARYLAND		24a. REC'D. BY REGISTRAR JUL 30 '58		24b. REG. STAR'S SIGNATURE <i>Alt. Reduch</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as a burial-transit permit. Then please remove carbon paper. Page 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8520

CERTIFICATE OF DEATH

05527

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Wicomico</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Hanover</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural</i>		c. LENGTH OF STAY IN 1b <i>4 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Snow Hill</i>		d. STREET ADDRESS <i>Collins Street</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Peninsula General Hospital</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First <i>John</i>	Middle <i>Banks</i>	Last <i>Manuel</i>	4. DATE OF DEATH <i>July 17- 1958</i>	Month <i>July</i>	Day <i>17</i>	Year <i>1958</i>
5. SEX <i>Male</i>		6. COLOR OR RACE <i>Colored</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>March 17 1902</i>	9. AGE (In years (<i>last birthday</i>) <i>56</i>)	10. UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. Hours <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Snow Hill</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>James Manuel</i>		14. MOTHER'S MAIDEN NAME <i>Venia Rowley</i>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Not now or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>216-10-3253</i>		17. INFORMANT <i>Paul Manuel</i>		2. E. BEL-D. Ave. Pennsgrange St. 5		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Chronic</i>		DUE TO <i>Chronic</i>		INTERVAL BETWEEN ONSET AND DEATH				
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO <i>Chronic Nephritis</i>		(c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>July 17 1958</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Snow Hill</i>		20f. (City or town) <i>Snow Hill</i>		(County) <i>Wicomico</i>
21. I certify that I attended the deceased from <i>7/17/58</i> to <i>7/17/58</i> , that I last saw the deceased alive on <i>7/17/58</i> and that death occurred at <i>8:45 AM</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>Snow Hill, Maryland</i>								DATE SIGNED <i>7/17/58</i>
ACTION SIGNATURE <i>Paul Manuel</i>		M.D. <i>None</i>						
NAME (Type) <i>James F. Banks</i>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>July 20/58</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Home Beneficial</i>		22d. LOCATION (City, town, or county) <i>Stockton, Maryland</i>		(State) <i>Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>James F. Banks, Snow Hill Md.</i>		ADDRESS		24a. REC'D BY REGISTRAR <i>JUL 21 1958</i>		24b. REGISTRAR'S SIGNATURE <i>Abraham</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as a burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8551 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

085528

**FOR STATE
HEALTH DEPT.**

VS. **DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the words "Pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Reg. Dist. No. _____											
1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pittsville		c. LENGTH OF STAY IN 1b 15 Yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pittsville		d. STREET ADDRESS Main St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Main St.											
3. NAME OF DECEASED (Type or print) Charles Lloyd McNeal		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year			
5. SEX M		6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 4-26-1909	9. AGE (In years last birthday) 49 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. HOURS Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Never Work		10b. KIND OF BUSINESS OR INDUSTRY invalid		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U S A					
13. FATHER'S NAME Daniel Richard McNeal		14. MOTHER'S MAIDEN NAME Marcia Lena Webb				Address Grazon McNeal, Wilmington, Del.					
16. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 976x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) DUE TO (c)											
17. INFORMANT None Mr. Grazon McNeal, Wilmington, Del.											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.											
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18) Shot self in head with gun at home.											
20c. TIME OF INJURY Month, Day, Year HOUR 6. m. 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> 11:30 P.M. 1. 7-21-58 at work <input type="checkbox"/> of work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) Home Pittsville Wicomico Md.											
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE  EXAMINER'S NAME (Type) Earl L. Royer, M.D.											
M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 7-24-58											
22a. BURIAL CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 7/24/58 22c. NAME OF CEMETERY OR CREMATORY Pittsville Cemetery 22d. LOCATION (City, town, or county) Pittsville, Maryland (State)											
23. FUNERAL DIRECTOR'S SIGNATURE Hill & Johnson Co., Salisbury, Maryland <i>Norman Baker</i>											
24a. REC'D BY REGISTRAR DATE JUL 28 '58 24b. REGISTRAR'S SIGNATURE <i>Alt. search</i>											
VS. ATSM SM 2 '52											



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8521 CERTIFICATE OF DEATH

Reg. Dist. No.

08521

1. PLACE OF DEATH a. COUNTY WICOMICO		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND		b. COUNTY WICOMICO		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SALISBURY		c. LENGTH OF STAY IN 1b 1 DAY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WILLARDS				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION PENINSULA GENERAL HOSPITAL		e. STREET ADDRESS		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First LUCINDA	Middle PERDUE	Last MITCHELL	4. DATE OF DEATH JULY 20 1958	Month JULY	Day 20	Year 1958	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 4, 1885	9. AGE (in years last birthday) 73 yrs.	10. UNDER 1 YEAR IF UNDER 24 HRS Months 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIF		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) POWELLYVILLE MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME JOHN GORDY PERDUE		14. MOTHER'S MAIDEN NAME SARAH ADKINS		Address				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no. If unknown, if yes, give war or date of service) No		16. SOCIAL SECURITY NO. No		17. INFORMANT Mrs. William Jarmon, Berlin MD		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular Accident DUE TO 2nd Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Arteriosclerotic Cerebrovascular Disease (c) DUE TO Arteriosclerotic Cerebrovascular Disease		INTERVAL BETWEEN ONSET AND DEATH 2 days
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)						
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. July 19 1958		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) PINEBHUFF RD.		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 7/19 , 1958, to 7/20 , 1958, that I last saw the deceased alive on 7/19 , 1958, and that death occurred at 671 M.D., from the causes and on the date stated above.								
ACTUAL SIGNATURE Rufus S. Gardner Jr.		ADDRESS (Street, city or town, state) PINEBHUFF RD.		DATE SIGNED 7/20/58				
PHYSICIAN'S NAME (Type) RUFUS S. GARDNER JR.		22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL						
22b. DATE THEREOF 7-20-58		22c. NAME OF CEMETERY OR CREMATORY ST. JOHNS		22d. LOCATION (City, town, or county) POWELLVILLE		(State) MD.		
23. FUNERAL DIRECTOR'S SIGNATURE Anna D. Burbage Berlin Md		ADDRESS		24a. REC'D. BY REGISTRAR JUL 23 1958		24b. REGISTRAR'S SIGNATURE W. Smith		
VS A15 (4) 1SM 10/57		DATE						



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as a burial-transit permit. Then please remove carbon paper. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18											
8522 CERTIFICATE OF DEATH											
Reg. Dist. No. 05530											
1. PLACE OF DEATH o COUNTY Wicomico				MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b 3 weeks				b. COUNTY Baltimore City			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital								c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
3. NAME OF DECEASED (Type or print) Ramon N. Gracia				First	Middle	Last	Naverette	4. DATE OF DEATH	Month	Day	Year
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/15/1923	9. AGE (In years last birthday) 35 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours	13. IF UNDER 24 HRS. Min.
10a. USJAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bar tender				10b. KIND OF BUSINESS OR INDUSTRY Bartender				11. BIRTHPLACE (State or foreign country) Mexico			
13. FATHER'S NAME Guillermo Naverette				14. MOTHER'S MAIDEN NAME ?				12. CITIZEN OF WHAT COUNTRY? ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) Unk				16. SOCIAL SECURITY NO.				17. INFORMANT Deer's Head State Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic coma INTERVAL BETWEEN ONSET AND DEATH 10 days 5/10 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first } (b) Cirrhosis of liver 6 months DUE TO DUE TO (c)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b)							
20c. TIME OF INJURY Month, Day, Year Hour o m p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)
21. I certify that I attended the deceased from June 18, 1958 , to July 11, 1958 , that I last saw the deceased alive on July 10, 1958 , and that death occurred at 2:45A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____											
ACTUAL SIGNATURE <i>G. Kosmahl</i>		M.D. _____		G. Kosmahl, M.D. _____		7/11/58					
PHYSICIAN'S NAME (Type) G. Kosmahl, M. D.		Deer's Head State Hospital, Salisbury, Md.									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 14/58		22c. NAME OF CEMETERY OR CREMATORIAL Baltimore National		22d. LOCATION (City, town, or county) Baltimore, Md.				(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Witzig Funeral Directors		ADDRESS 4101 Edmondson Ave.				24a. REC'D BY REGISTRAR JUL 14 '58		24b. REGISTRAR'S SIGNATURE <i>Albert Leach</i>			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

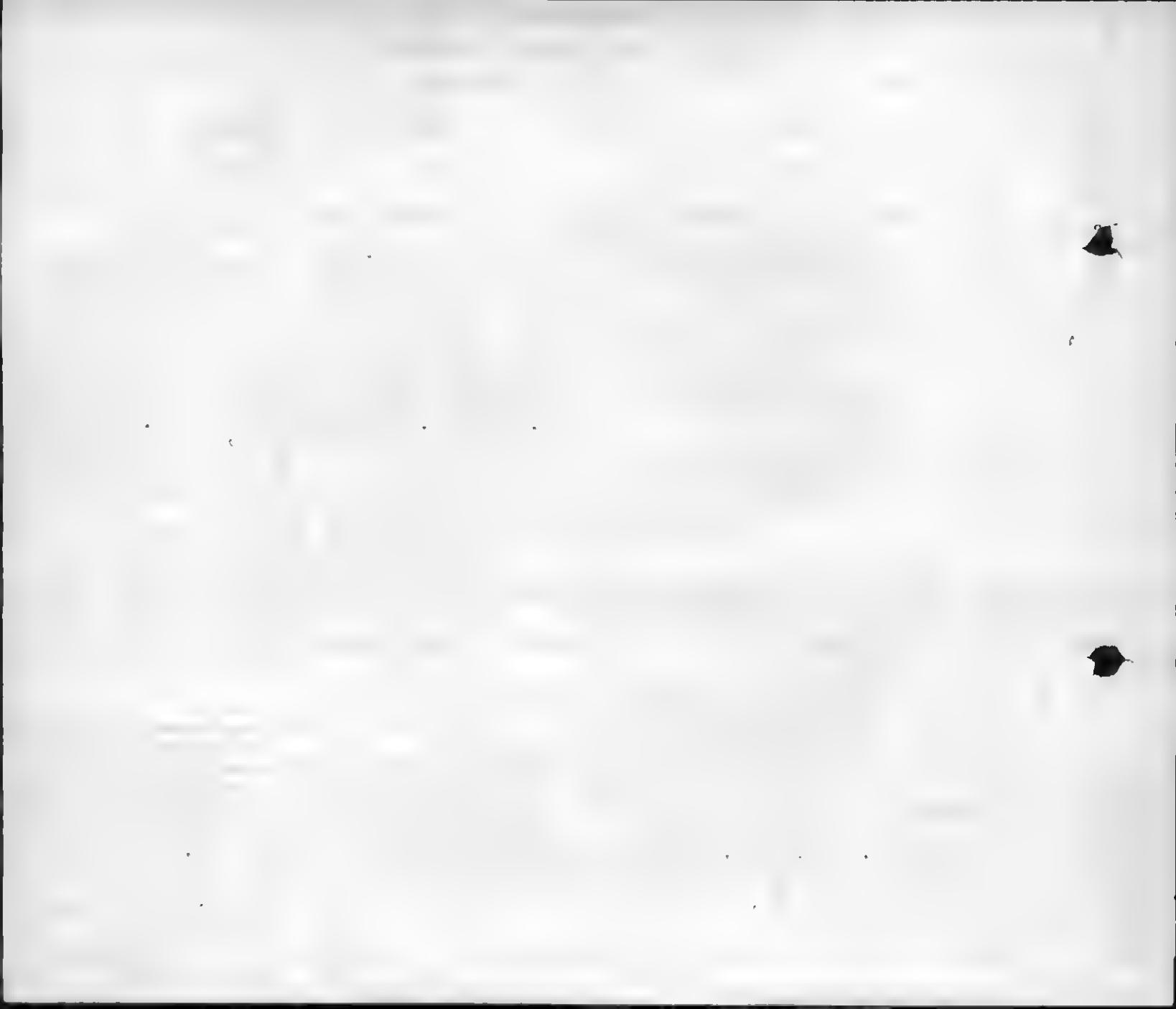
8523

CERTIFICATE OF DEATH

Reg. Dist. No. 85531

1. PLACE OF DEATH a. COUNTY <i>Wicomico Co.</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <i>Virginia</i>		b. COUNTY <i>Accomac</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>SALISBURY</i>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Chincoteague</i>		d. STREET ADDRESS <i>147 E KEARSARGE AVENUE</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>TENNESSEE GENERAL Hospital</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <i>Clyde Wright</i>		First <i>Clyde</i>	Middle <i>Wright</i>	Last <i>Newton</i>	4. DATE OF DEATH <i>JULY 9, 1958</i>	Month <i>JULY</i>	Day <i>1</i>	Year <i>1958</i>
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>JULY 9, 1958</i>		9. AGE (In years lost birthday) yrs. <i>71</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>RUNE</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>NONE</i>		11. BIRTHPLACE (State or foreign country) <i>SALISBURY, MARYLAND</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>Clyde Wright Newton</i>				14. MOTHER'S MAIDEN NAME <i>Ann Rosemary Brogan</i>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Mr. Clyde W. Newton (Father) 147 E Kearsarge Circle - Chincoteague, Virginia</i>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>7625</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO (c)				Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Atelectasis Pneumonitis (21bs - 10oz)</i>				
INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Medical Center - Salisbury, Maryland</i>		20f. (City or town) (County) / (State)		
21. I certify that I attended the deceased from <i>7/9</i> , 19 <i>58</i> , to <i>7/11</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>7/11</i> , 19 <i>58</i> , and that death occurred at <i>1-508 M</i> , from the causes and on the date stated above.								
ADDRESS (Street, city or town, state) <i>MD.</i>								
DATE SIGNED <i>July 11 1958</i>								
ACTUAL SIGNATURE <i>Alfred C. Kolls</i>		PHYSICIAN'S NAME (Type) <i>Dr. Alfred C. Kolls</i>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>July 12, 1958</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Wicomico Memorial Park</i>		22d. LOCATION (City, town, or county) (State) <i>Salisbury, Maryland</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>HOLLOWAY & COMPANY</i>		ADDRESS <i>SALISBURY MARYLAND</i>		24a. REC'D BY REGISTRAR DATE <i>JUL 14 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Alfred C. Kolls</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician, who has been signed by the attending physician and completely filled in by the medical director. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as a burial-transit permit. Then please remove carbon paper. Page 3 should be detached for use at the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05532

8524

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
NICOMICO MARYLAND		a. STATE	b. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SALISBURY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SALISBURY X	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS HILL & JOHNSON, SALISBURY, MD. #1	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Jeanne	Middle MARGARET	Last Nicholson
4. DATE OF DEATH	Month July	Day 16	Year 1958
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN 16, 1957
9. AGE (In years lost or birthday) yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child	10b. KIND OF BUSINESS OR INDUSTRY —	11. BIRTHPLACE (State or foreign country) MARYLAND	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME JAMES L. Nicholson	14. MOTHER'S MAIDEN NAME Jane Pitch Ford		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown)	16. SOCIAL SECURITY NO —	17. INFORMANT Mr. James L. Nicholson, Same.	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH 1 day	
DUE TO <i>Nemungococcic Septicemia</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) ADDRESS (Street, city or town, state)	
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>7-15</u> , 1958, to <u>7-16</u> , 1958, that I last saw the deceased alive on <u>JULY 16</u> , 1958, and that death occurred at <u>8 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Lee L. Lawry</i>	M.D.	<u>FRUITLAND, MD.</u>	DATE SIGNED <u>7/16/58</u>
PHYSICIAN'S NAME (Type) <i>Dr. Lee Lawry</i>		ADDRESS (Street, city or town, state) <i>FRUITLAND, MARYLAND</i>	
22a. BURIAL, CREMATION, BROKEN BONES	22b. DATE THEREOF <u>BURIAL 7/17/58</u>	22c. NAME OF CEMETERY OR CREMATORIUM <u>NICOMICO MEM. PK SALISBURY, MD</u>	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>Hill & Johnson, SALISBURY, MD.</i>	ADDRESS <i>Norman & Baker</i>	24a. REC'D BY REGISTRAR <u>JUL 18 '58</u>	24b. REGISTRAR'S SIGNATURE <i>W. Heuer</i>

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as a burial-transit permit. Then please remove carbon paper. Page 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

111-266197

P. 1 A.

10

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8552 CERTIFICATE OF DEATH

08533

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY

Wicomico

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Nanticoke

c. LENGTH OF STAY IN 1b

Lifetime

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)

a. STATE

Maryland

b. COUNTY

Wicomico

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Nanticoke

d. STREET ADDRESS

e. IS RESIDENCE
ON A FARM?
YES NO 3. NAME OF
DECEASED
(Type or print)

CLARA

First

Middle

Last

NUTTER

4. DATE
OF
DEATH

July

19

19

58

5. SEX

Female

6. COLOR OR RACE

Negro

7. MARRIED NEVER MARRIED WIDOWED

8. DATE OF BIRTH

4/26/84

9. AGE (In years
lost birthday)

74 yrs.

10. IF UNDER 1 YEAR

2 Months

11. IF UNDER 24 HRS

2 Days

10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

Own Home

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.

13. FATHER'S NAME

William H. Bradshaw

14. MOTHER'S MAIDEN NAME

Amelia Elsey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)

No

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

Westley Nutter, Nanticoke, Maryland

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

331X

DUE TO

Conditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause last.

(b)

DUE TO

(c)

Cerebral Hemorrhage

INTERVAL BETWEEN
ONSET AND DEATH
16 hrs.

Arteriosclerosis Generalized. 5 Years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?YES NO 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour o. m. 19 p. m.

20d. INJURY OCCURRED

While Not while
of work of work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from 28 Aug., 1950, to 19 July, 1958, that I last saw the deceased
alive on 19 July, 1958, and that death occurred at 9:45 A.M., from the causes and on the date stated above.
ADDRESS (Street, city or town, state)ACTUAL
SIGNATUREPHYSICIAN'S
NAME (Type)

Richard H. Saunders

Nanticoke, Maryland

7/21/58

DATE SIGNED
7/21/5822a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

22b. DATE THEREOF

7/22/58

22c. NAME OF CEMETERY OR CREMATORIUM

Nanticoke Cem.

22d. LOCATION (City, town, or county)

Nanticoke, Maryland

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

C. D. Jessup, Bivalve, Maryland

ADDRESS

24a. REC'D BY REGISTRAR
JUL 25 195824b. REGISTRAR'S SIGNATURE
John L. Conner



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 1B. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMJ. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										Reg. Dist. No. 05534																
8525 MEDICAL EXAMINER'S CERTIFICATE OF DEATH																										
1. PLACE OF DEATH a. COUNTY Wicomico			MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Wicomico																				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			c. LENGTH OF STAY IN lb			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 12 Salisbury			d. STREET ADDRESS Cloverdale Road																	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Tony Tank Manor									e. IS RE IDENT. ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
3. NAME OF DECEASED (Type or print) First EUGENE Middle KYLE Last OAKLEY			4. DATE OF DEATH JULY 19th 1958			5. SEX Male			6. COLOR OR RACE White			7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH Feb. 21, 1907			9. AGE (in years (on birthday) 51 yes.			10. IF UNDER 1 YEAR Months 4 Days 28			11. IF UNDER 24 HRS Hours 28 Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Builder (Masonary)			10b. KIND OF BUSINESS OR INDUSTRY Contractor			11. BIRTHPLACE (State or foreign country) Virginia (Galax)			12. CITIZEN OF WHAT COUNTRY? U.S.A.																	
13. FATHER'S NAME William Edgar Oakley			14. MOTHER'S MAIDEN NAME Cena Rector																							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO.			17. INFORMANT Mrs. Viva S. Oakley (Wife) Address Salisbury, Maryland																				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																										
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			DUE TO Coronary Occlusion			INTERVAL BETWEEN ONSET AND DEATH Trudeler																				
Conditions, if any, which gave rise to immediate cause (b), stealing the underlying cause lost.			DUE TO arterio venous fistula			TIME yr																				
DUE TO (c)																										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																							
20c. TIME OF INJURY Hour e. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)																	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>																										
ACTUAL SIGNATURE <i>Dr. Earl L. Royer</i>			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>																		DATE SIGNED July 21/1958					
22a. BURIAL CREMATION REMOVAL (Specify) Burial			22b. DATE THEREOF July 22, 1958			22c. NAME OF CEMETERY OR CREMATORIUM Wicomico Memorial Park			22d. LOCATION (City, town, or county) Salisbury, Maryland																	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY			ADDRESS SALISBURY MARYLAND			24a. REC'D BY REGISTRAR DATE JUL 24 '58			24b. REGISTRAR'S SIGNATURE <i>Reed</i>																	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

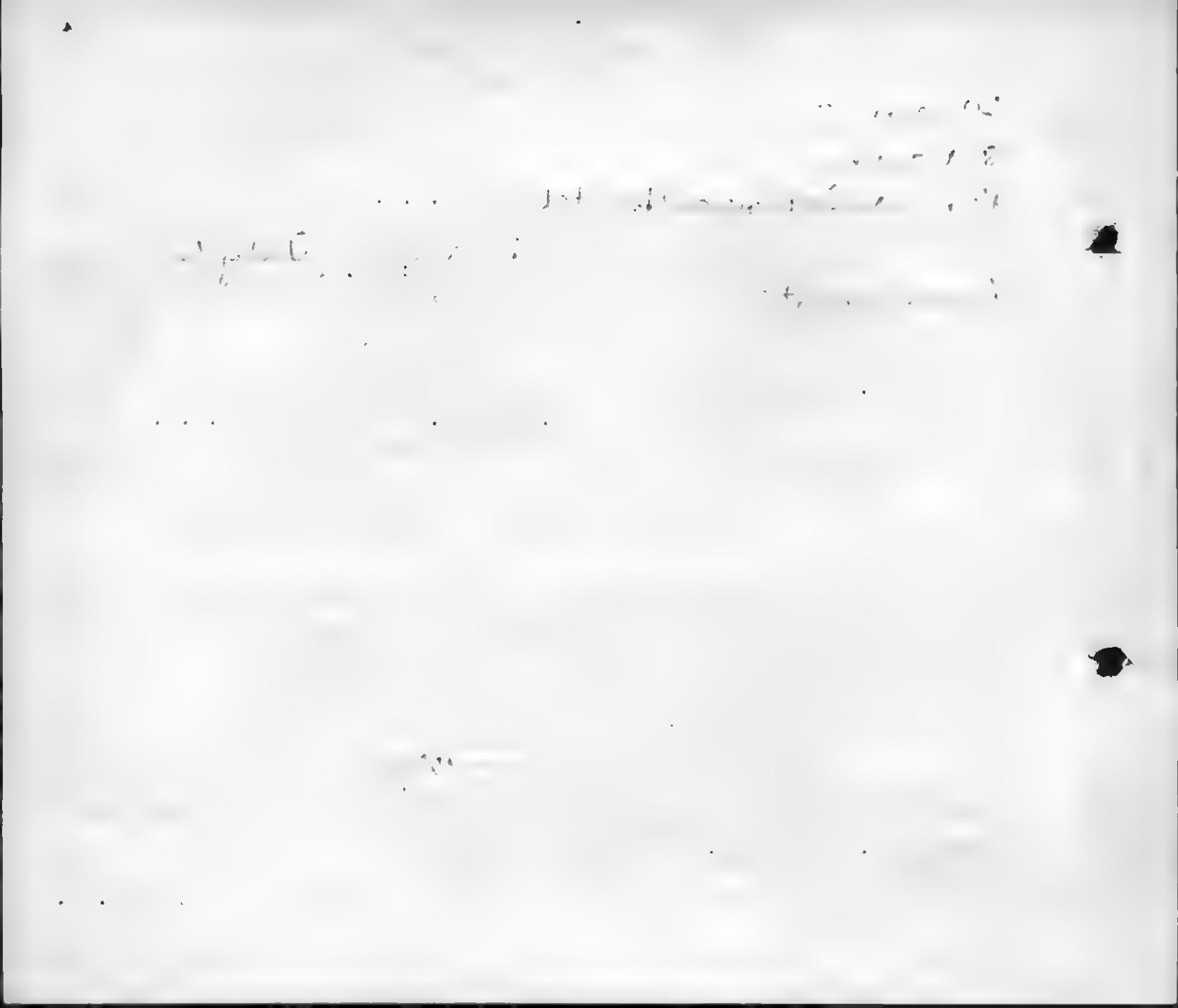
8526

CERTIFICATE OF DEATH

Reg. Dist. No. 18535

1. PLACE OF DEATH a. COUNTY <i>Wicomico</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Wicomico</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Salisbury</i>		c. LENGTH OF STAY IN lb <i>Parsonsburg</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Parsonsburg</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Peninsula General Hospital</i>		e. STREET ADDRESS <i>P.O.B.# 54</i>		d. STREET ADDRESS <i>P.O.B.# 54</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <i>JOIE</i>	Middle <i></i>	Last <i>Perdue</i>	4. DATE OF DEATH <i>July 16 - 1958</i>	Month <i>JULY</i>	Day <i>16</i>	Year <i>1958</i>
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <i>Baby</i>	B. DATE OF BIRTH <i>10:06 P.M.</i>	C. AGE (in years, less birthday) <i>0 yrs</i>	D. UNDER 1 YEAR <i>0 months</i>	E. UNDER 24 HRS. <i>0 days</i>	F. HOURS <i>0 hrs</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>		11. BIRTHPLACE (State or foreign country) <i>Salisbury, Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Lewis W. Perdue</i>				14. MOTHER'S MAIDEN NAME <i>Ella White</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>Mr. Lewis W. Perdue (Father) Address Parsonsburg, Maryland</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Asphyxia Neonatorum</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO <i>Premature 450 gms (5 month gestation)</i> (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>Parsonsburg</i>	(County) <i></i>	(State) <i>Md.</i>
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at <i>10:06 P.M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE <i>William C. Morgan M.D.</i> DATE SIGNED <i>July 17, 1958</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> 22b. DATE THEREOF <i>July 17, 1958</i> 22c. NAME OF CEMETERY OR CREMATORIUM <i>Parsonsburg Cemetery</i> 22d. LOCATION (City, town or county) <i>Parsonsburg, Md.</i> (State)							
23. FUNERAL DIRECTOR'S SIGNATURE <i>HOLLOWAY & COMPANY</i>				ADDRESS <i>SALISBURY MARYLAND</i>		24a. REC'D BY REGISTRAR DATE <i>JUL 21 '58</i>	24b. REGISTRAR'S SIGNATURE <i>John Morgan</i>

TO HOSPITAL OR ATTENDIN PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as a burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the rail-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

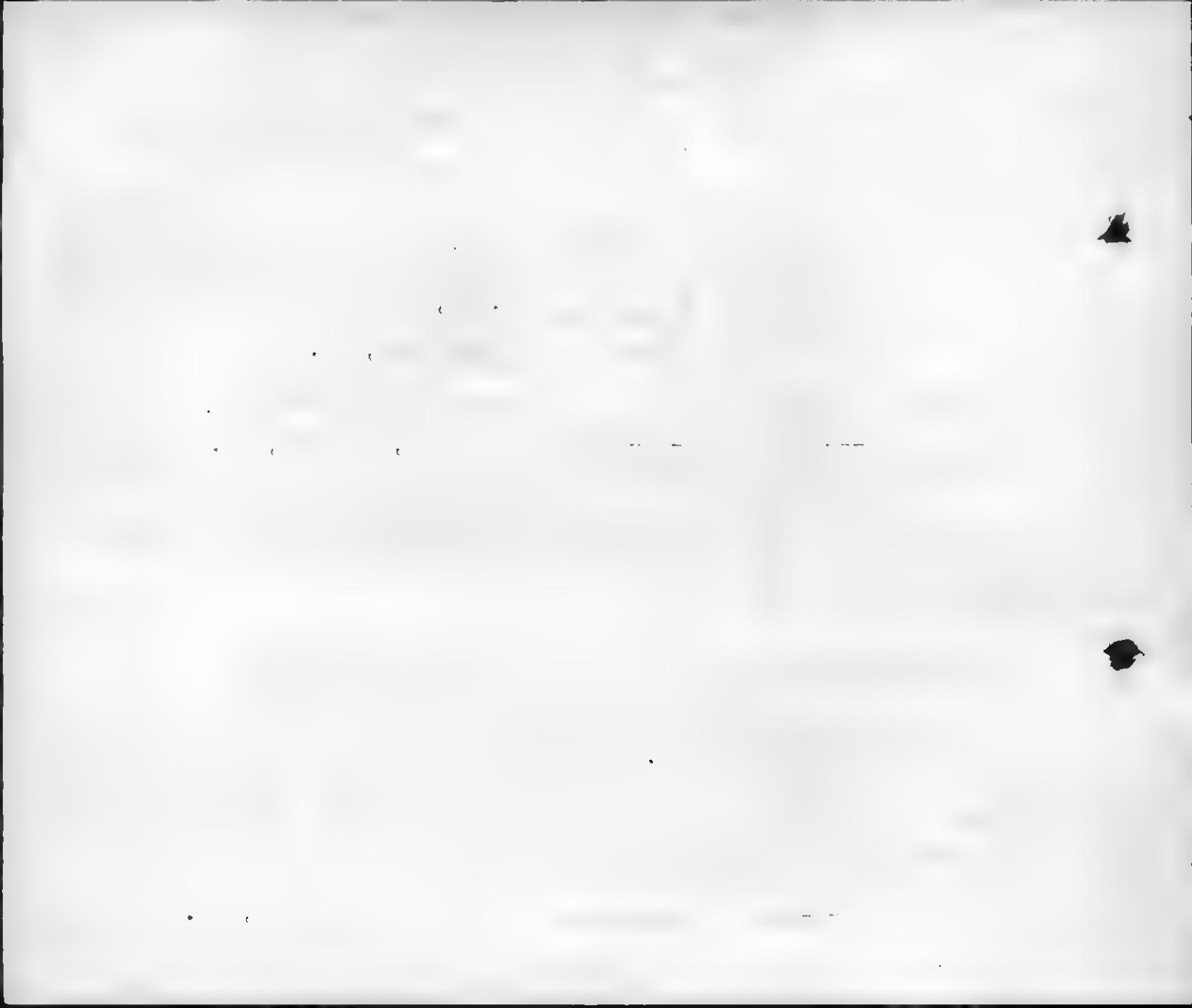
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08536

CERTIFICATE OF DEATH

Reg. Dist. No.

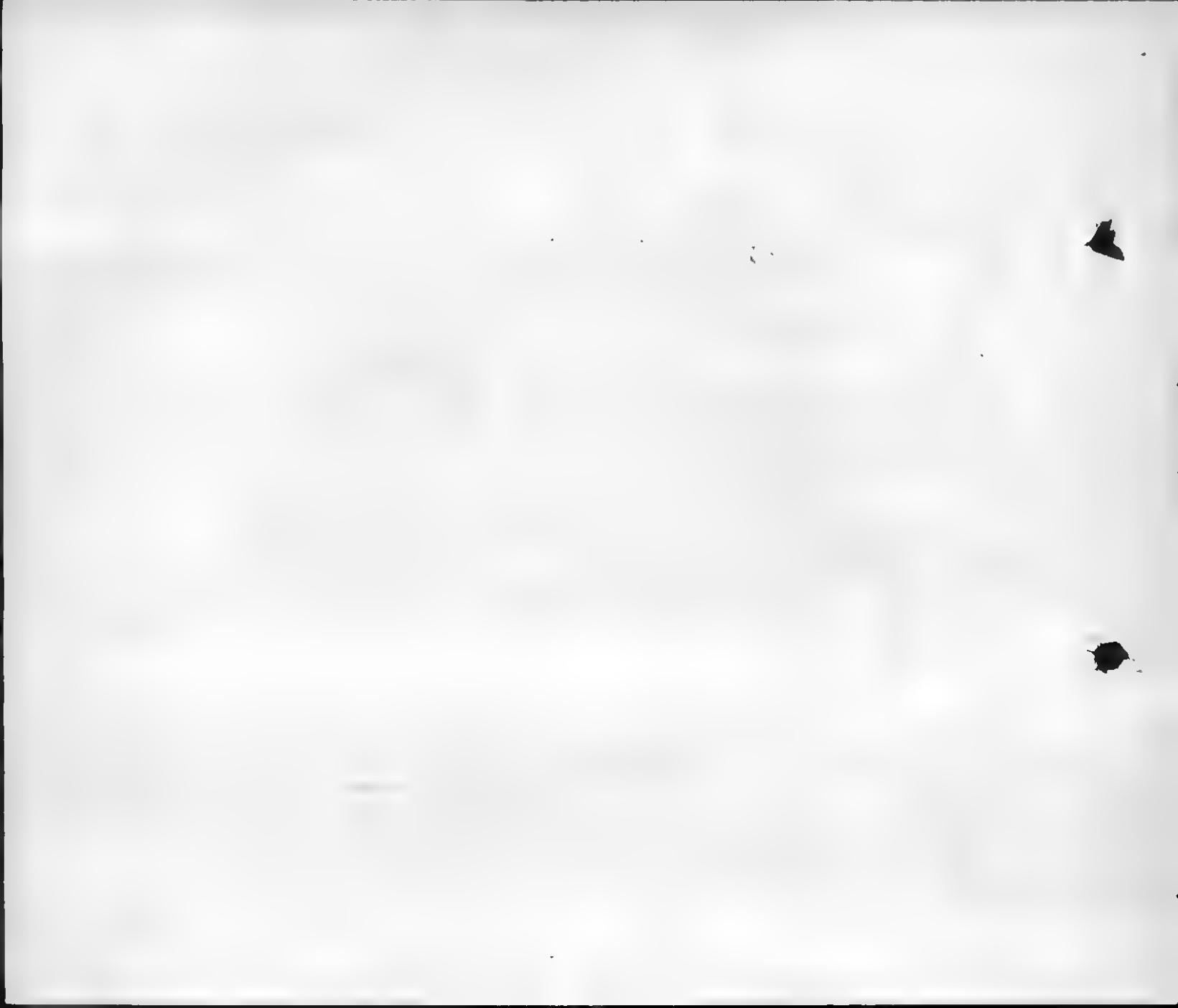
1. PLACE OF DEATH a. COUNTY Wicomico		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland		b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Delmar		c. LENGTH OF STAY IN lb 1 week		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sharptown		d. STREET ADDRESS 102 Spruce Street	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 102 Spruce Street						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Kate		First Edna	Middle Phillips	Last July	4. DATE OF DEATH 17	Month 19	Day 58
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 12, 1879	9. AGE (In years last birthday) 79 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Sharptown, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thomas W. Walker		14. MOTHER'S MAIDEN NAME Mary Ellen Connely		Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 214-18-4346		17. INFORMANT Edna Ellis, Delmar, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4.4x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) DUE TO (c)		<i>Cerebral Hemorrhage</i>		INTERVAL BETWEEN ONSET AND DEATH July 18-58			
		<i>Hypertensive Cerebral Hemorrhage</i>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 12, 1958 , to July 12, 1958 , that I last saw the deceased alive on July 12, 1958 , and that death occurred at M. from the causes and on the date stated above				ADDRESS (Street, city or town, state)		DATE SIGNED July 18-58	
ACTUAL SIGNATURE J. H. Lynch		PHYSICIAN'S NAME (Type) J. H. Lynch		M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-20-58		22c. NAME OF CEMETERY OR CREMATORIUM Firemans		22d. LOCATION (City, town, or county) (State) Sharptown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Chad W. Ward, Sharptown, Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE JUL 22 '58		24b. REGISTRAR'S SIGNATURE W. Ward	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as a mail-transit permit. Then please remove carbon paper. Page 2 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 8527 CERTIFICATE OF DEATH										Reg. Dist. No. 08537				
1. PLACE OF DEATH a. COUNTY WICOMICO MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND b. COUNTY WORCESTER									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SALISBURY 9 DAYS					CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pocomoke CITY 2141									
c. LENGTH OF STAY IN 1b					d. STREET ADDRESS 75 ST REET					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION PENINSULA GENERAL HOSPITAL														
3. NAME OF DECEASED (Type or print) MAY C. PHILLIPS					4. DATE OF DEATH JULY 18, 1958									
5. SEX Female COLOR OR RACE WHITE MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 6. DATE OF BIRTH DEC. 14 1899					7. IF UNDER 1 YEAR OF AGE UNDER 24 HRS. Months Days Hours Min.									
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					8. AGE (In years lost birthday) 58 yrs.									
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE					10b. KIND OF BUSINESS OR INDUSTRY —					11. BIRTHPLACE (State or foreign country) MARYLAND				
13. FATHER'S NAME HENRY C. OUTEN					14. MOTHER'S MAIDEN NAME MARY F. RITCHIE					12. CITIZEN OF WHAT COUNTRY? USA				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? NO					16. SOCIAL SECURITY NO. —					17. INFORMANT Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4a.v. DUE TO Coronary Artery Thrombosis 9 days Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) " Attherosclerosis										INTERVAL BETWEEN ONSET AND DEATH				
(c)														
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (d) 20. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)				
20c TIME OF INJURY Month, Day, Year Hour e. m. 19					20d INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				
20f. (City or town) (County) (State)														
21. I certify that I attended the deceased from July 9, 1958, to July 18, 1958, that I last saw the deceased alive on July 10, 1958, and that death occurred at 16 M. from the causes and on the date stated above. ACTUAL SIGNATURE <i>Pat J. Watson</i> ADDRESS (Street, city or town, state) <i>Salisbury, Md.</i> DATE SIGNED <i>July 18, 1958</i>														
PHYSICIAN'S NAME (Type)														
22a BURIAL, CREMATION, REMOVAL (Specify) BURIAL 7-20-58					22b. DATE THEREOF 7-20-58					22c NAME OF CEMETERY OR CREMATORIUM BAPTIST CEMETERY				
22d LOCATION (City, town, or county) Poocomoke City, Maryland (State)														
23. FUNERAL DIRECTOR'S SIGNATURE <i>Henry St. Watson</i>					ADDRESS <i>Pocomoke City, Md.</i>					24a REC'D BY REGISTRAR DATE <i>July 22 '58</i>				
										24b REGISTRAR'S SIGNATURE <i>John E. Johnson</i>				



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 18553X

1. PLACE OF DEATH a. COUNTY <u>WICOMICA</u>		MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u>		b. COUNTY <u>SOMERSET</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. LENGTH OF STAY IN 1b <u>PENINSULA GENERAL HOSPITAL</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PRINCESS ANN ISL.</u>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First <u>WINIFRIED</u>	Middle <u></u>	Last <u>POWELL</u>	4. DATE OF DEATH <u>July 12 1958</u>	Month <u>JULY</u>	Day <u>12</u>	Year <u>1958</u>	
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 19 1891</u>	9. AGE (In years at birthday) <u>66 yrs.</u>	10. IF UNDER 1 YEAR Months <u></u>	11. IF UNDER 24 HRS. Days <u></u>	Hours <u></u>	Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>James H. Spencer</u>		14. MOTHER'S MAIDEN NAME <u>Emma Bishop</u>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT <u>Arthur Powell Princess Anne</u>		Address <u></u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>170X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <u></u>		(b) <u>Carcinoma rt. breast inoperable</u> DUE TO <u>with gen. metastases</u>		(c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>See 1957</u>			
19. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) <u></u>		(County) <u></u>	(State) <u></u>
21. I certify that I attended the deceased from <u>Dec. 1957</u> to <u>July 12 1958</u> , that I last saw the deceased alive on <u>July 12 1958</u> , and that death occurred at <u>10:30 P.M.</u> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <u></u>							
ACTUAL SIGNATURE <u>William B. Jones</u>		DATE SIGNED <u>7/12/58</u>							
PHYSICIAN'S NAME (Type) <u></u>									

22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7-15-58</u>	22c. NAME OF CEMETERY OR CREMATORIUM <u>Maryland Cemetery</u>	22d. LOCATION (City, town, or county) <u>Princess Anne Co.</u>	(State) <u>Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lewis R. Wilson</u>	ADDRESS <u>Princess Anne Co.</u>	24a. REC'D BY REGISTRAR DATE JUL 17 '58	24b. REGISTRAR'S SIGNATURE <u>Abdullah</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use as a burial transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8529 CERTIFICATE OF DEATH

Reg. Dist. No.

18533

1. PLACE OF DEATH a. COUNTY WICOMICO		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE MARYLAND		b. COUNTY WICOMICO	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SALISBURY		c. LENGTH OF STAY IN lb 3 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SALISBURY			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION FENWICK GENERAL HOSPITAL		d. STREET ADDRESS 1102 CAMDEN AVE.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Lucille	Middle Long	Last Purnell	4. DATE OF DEATH	Month July	Day 11	Year 1958
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT 20, 1897	9. AGE (in years last birthday) 64 yrs.	10. UNDER 1 YEAR Months 0	11. UNDER 24 HRS Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN Home		10c. BIRTHPLACE (State or foreign country) MARYLAND		11. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John I. T. Long		14. MOTHER'S MAIDEN NAME CORA DishAROON		Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no; unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT R.R. PURNELL, SAME		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subarachnoid Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cerebro-Vascular Disease DUE TO (c) Essential Hypertension	
INTERVAL BETWEEN ONSET AND DEATH 40 hrs.							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. March 19 1958		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Parsons Cemetery		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 1958 to July 11, 1958 , that I last saw the deceased alive on July 11, 1958 , and that death occurred at 8:25 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Thomas C. Hill Jr. M.D. ADDRESS (Street, city or town, state) SALISBURY, MARYLAND. 7/11/58. DATE SIGNED							
PHYSICIAN'S NAME (Type) Thomas C. Hill, Jr. Pine Buff Rd., SALISBURY, MARYLAND							
22a. BURIAL CREMATION, DATE THEREOF REMOVAL (Specify)		22b. NAME OF CEMETERY OR CREMATORIUM PARSONS CEMETERY		22c. LOCATION (City, town, or county) SALISBURY, MARYLAND.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Hill & Johnson SALISBURY, MD.		ADDRESS Norman F. Baker		24a. REC'D BY REGISTRAR DATE JUL 15 '58		24b. REGISTRAR'S SIGNATURE Dee E. Smith	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as an air-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as a strongarm permit. Then please remove carbon papers. Page 3 should be retained by the registrar prior to burial, cremation, or removal and in any event within 72 hours after death.

VS AIII (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 5. — See birth certificate of same date
Item 2. —

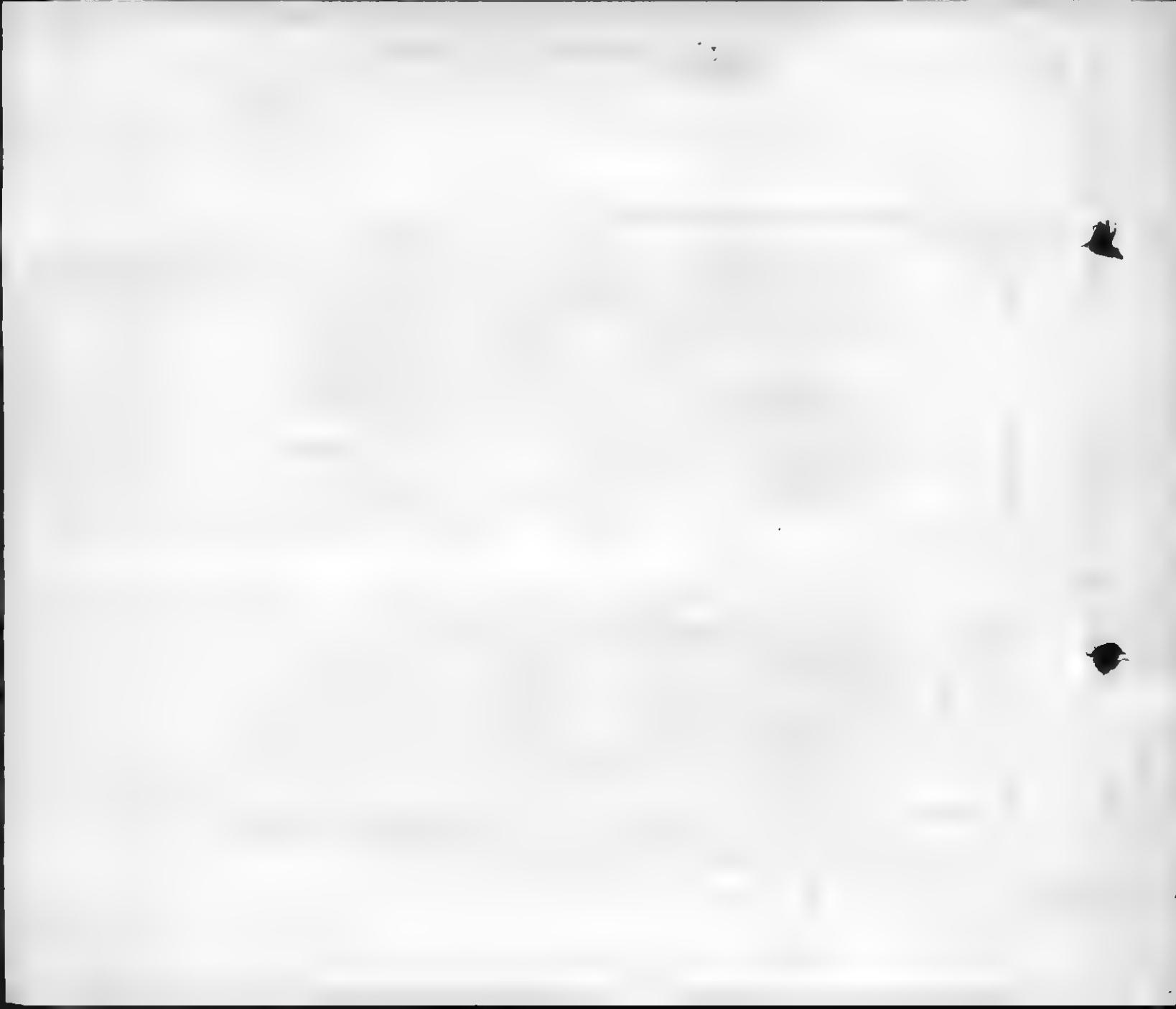
8530

CERTIFICATE OF DEATH

08540

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Worcester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b RURAL		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ocean City		d. STREET ADDRESS Box 142	
d. NAME OF HOSPITAL (If not in hospital, give street address), or INSTITUTION Peninsula General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First	Middle	4. DATE OF DEATH Redden	Month	Day	Year
5. SEX Female		6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 27 1958	9. AGE (In years last birthday) yrs. 71	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) SALISBURY MD		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Redden		14. MOTHER'S MAIDEN NAME ETHEL CLARKE		Address Mr John Redden Ocean City MD			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) No		16. SOCIAL SECURITY NO. —		17. INFORMANT —		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart attack DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. High blood pressure (b) Stroke DUE TO (c) —	
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		INTERVAL BETWEEN ONSET AND DEATH —		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20d. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7/27/58 , to 7/27/58 , that I last saw the deceased alive on 7/27/58 , and that death occurred at 8:30 AM , from the causes and on the date stated above. ACTUAL SIGNATURE John Redden PHYSICIAN'S NAME (Type)		ADDRESS (Street, city or town, state) —		DATE SIGNED 7/28/58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/26/58		22c. NAME OF CEMETERY OR CREMATORIUM Evergreen		22d. LOCATION (City, town or county) Bethel (State) MD	
23. FUNERAL DIRECTOR'S SIGNATURE Donna St. Bubba Berlin MD		ADDRESS —		24a. REC'D BY REGISTRAR DATE JUL 31 '58		24b. REGISTRAR'S SIGNATURE Albert	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08541

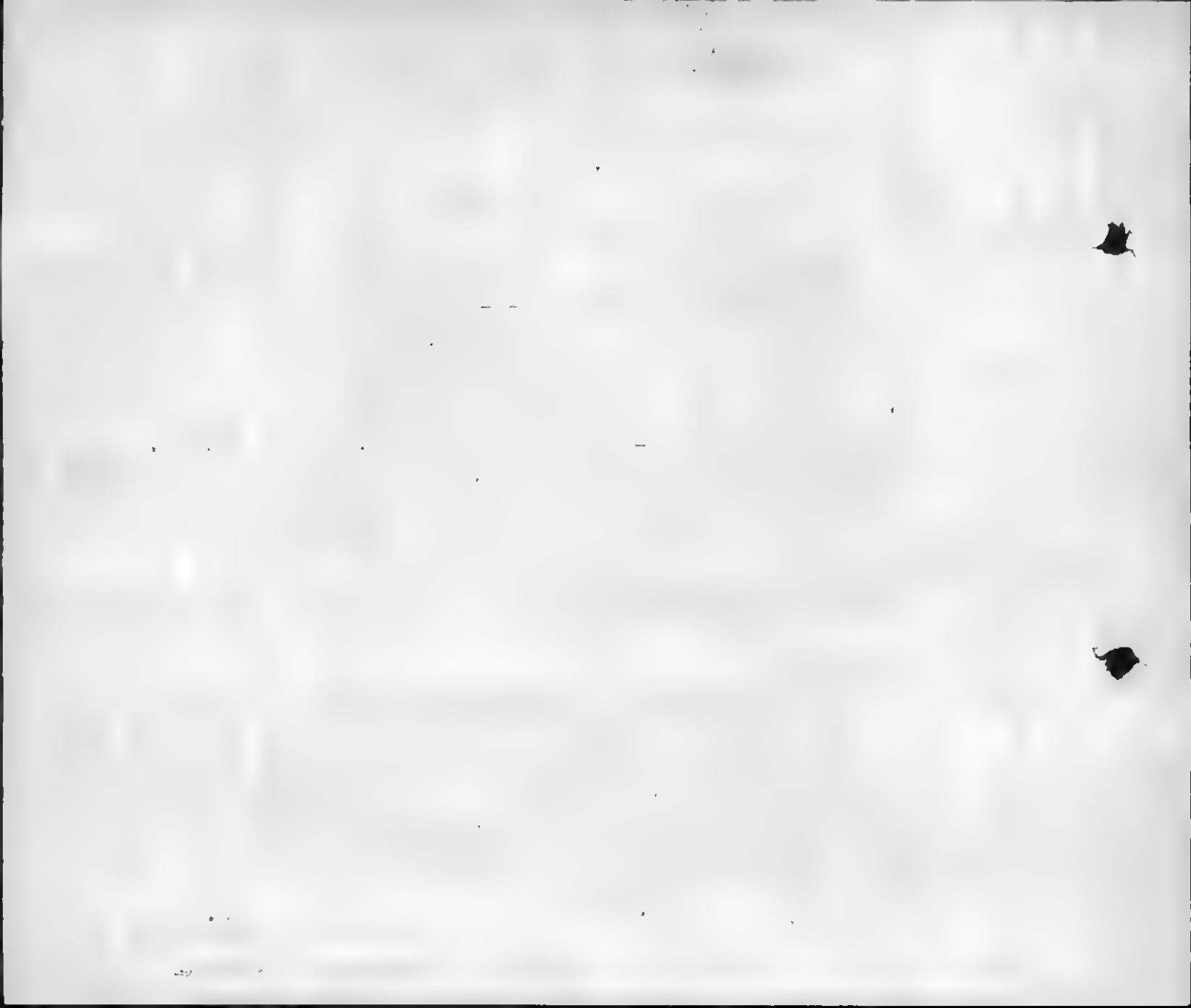
8531

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland		b. COUNTY Wicomico		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 2 mos.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 603 Dover Street				d. STREET ADDRESS 603 Dover Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Edward Allen Robbins		First	Middle	Last	4. DATE OF DEATH July 8 1958	Month	Day	Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH 7-9-1887	9. AGE (In years last birthday) 70 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours	13. IF UNDER 24 HRS Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Olin K. Robbins		14. MOTHER'S MAIDEN NAME Emory Colonna						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 717-09-2801		17. INFORMANT Virginia Carr, Salisbury, Md.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arterio Constriction Cardiac failure</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Hypertension & Degenerative heart disease</i> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Delmar Del.		20f. (City or town) Delmar		(County) Del. (State) Del.
21. I certify that I attended the deceased from July 8 , 1958, to July 8 , 1958, that I last saw the deceased alive on July 8 , 1958, and that death occurred at 309 N. Main St. from the causes and on the date stated above.						ADDRESS (Street, city or town, state) Delmar Del.		DATE SIGNED 7-9-58
ACTUAL SIGNATURE <i>S. H. Lynch</i>				M.D. <i>S. H. Lynch</i>				
PHYSICIAN'S NAME (Type) S. H. Lynch						<i>Delmar Del.</i>		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-11-58		22c. NAME OF CEMETERY OR CREMATORIUM Mt. Olive		22d. LOCATION (City, town, or county) Delmar, Del.		(State) Del.
23. FUNERAL DIRECTOR'S SIGNATURE <i>W. S. Marshall Co. - Delmar, Del.</i>		ADDRESS		24a. REC'D BY REGISTRAR DATE JUL 14 '58		24b. REGISTRAR'S SIGNATURE <i>Archibald</i>		

1. SPITAL OR ATTEND. PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.
 2. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the original-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



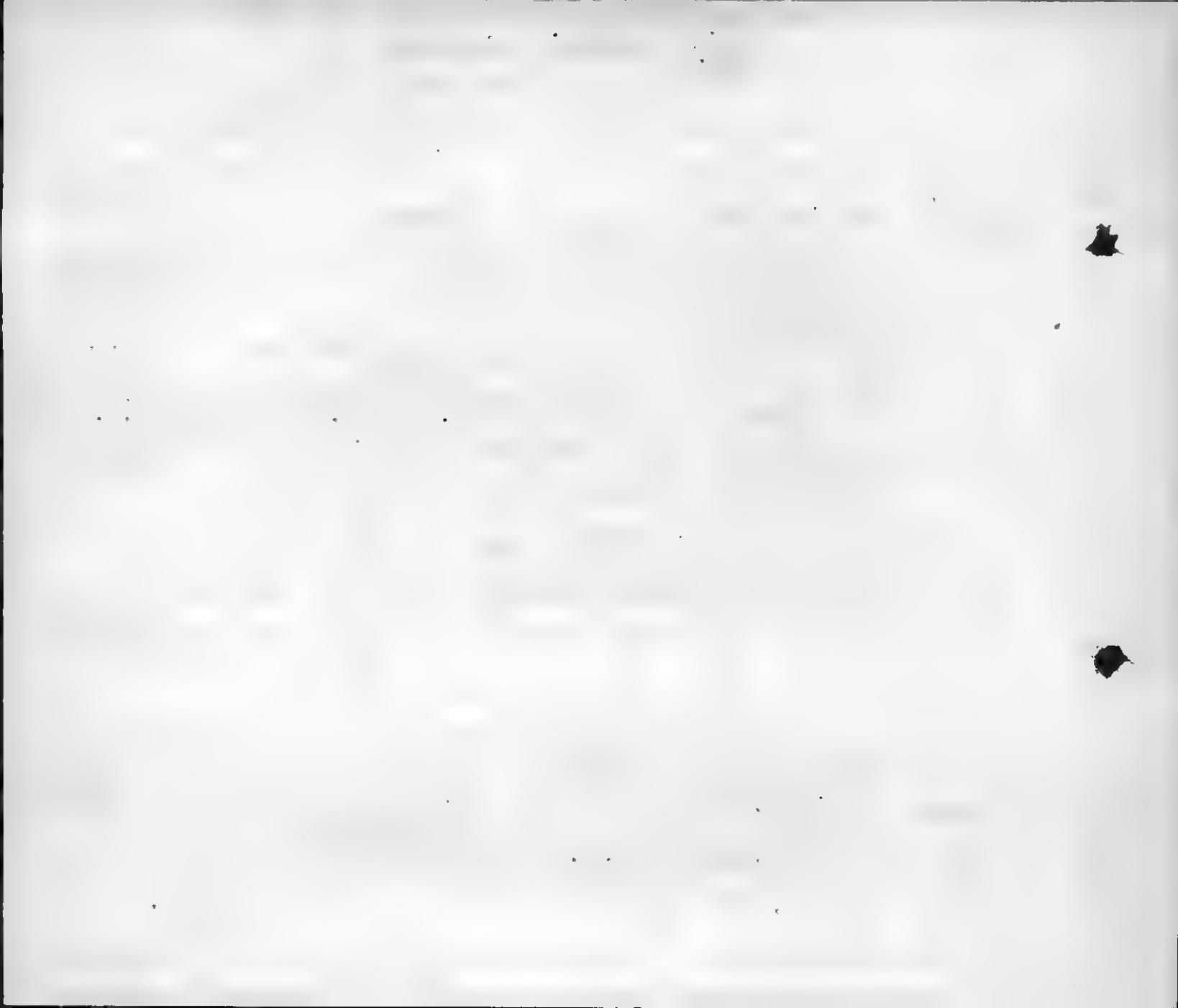
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8532 CERTIFICATE OF DEATH

18542

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN lb 21 days		2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland		b. COUNTY Wicomico	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		d. STREET ADDRESS Route 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Grace	Middle Elwood	Last Robbins	4. DATE OF DEATH July 1 1958	Month July	Day 1	Year 1958		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED	8. DATE OF BIRTH June 28, 1871	9. AGE (In years last birthday) 87 yrs.	10. IF UNDER 1 YEAR, IF UNDER 24 HRS. Months 87	Days 0	Hours 0	Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Bristol, Rhode Island		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME James Gayton			14. MOTHER'S MAIDEN NAME Sarah A. Blount			Salisbury, Maryland			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Unk		16. SOCIAL SECURITY NO.		17. INFORMANT Mr. Henry E. Sweet (Stephephew) R.D.# 1 Hospital Records, Deer's Head State Hospital					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 174X		Carcinomatosis		DUE TO		INTERVAL BETWEEN ONSET AND DEATH ?			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. {		(b) Ca. of uterus		DUE TO		?			
(c)									
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from June 10, 1958 , to July 1, 1958 , that I last saw the deceased alive on July 1, 1958 , and that death occurred at 9:30A.M. from the causes and on the date stated above.				ADDRESS (Street, city or town, state) Deer's Head State Hospital		DATE SIGNED 7/1/58			
ACTUAL SIGNATURE <i>G. Kosmahl, M. D.</i>		M.D.		Deer's Head State Hospital Salisbury, Maryland					
PHYSICIAN'S NAME (Type) G. Kosmahl, M. D.				Deer's Head State Hospital		7/1/58			
22a. BURIAL, CREMATON, REMOVAL (SPECIFY) Burial July 5, 1958		22b. DATE THEREOF July 5, 1958		22c. NAME OF CEMETERY OR CREMATORIUM Swan Lake Cemetery		22d. LOCATION (City, town, or county) Dennisport- Mass. (State)			
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		ADDRESS SALISBURY MARYLAND		24a. REC'D BY REGISTRAR DATE JUL 2 '58		24b. REGISTRAR'S SIGNATURE <i>Alfred Deacon</i>			



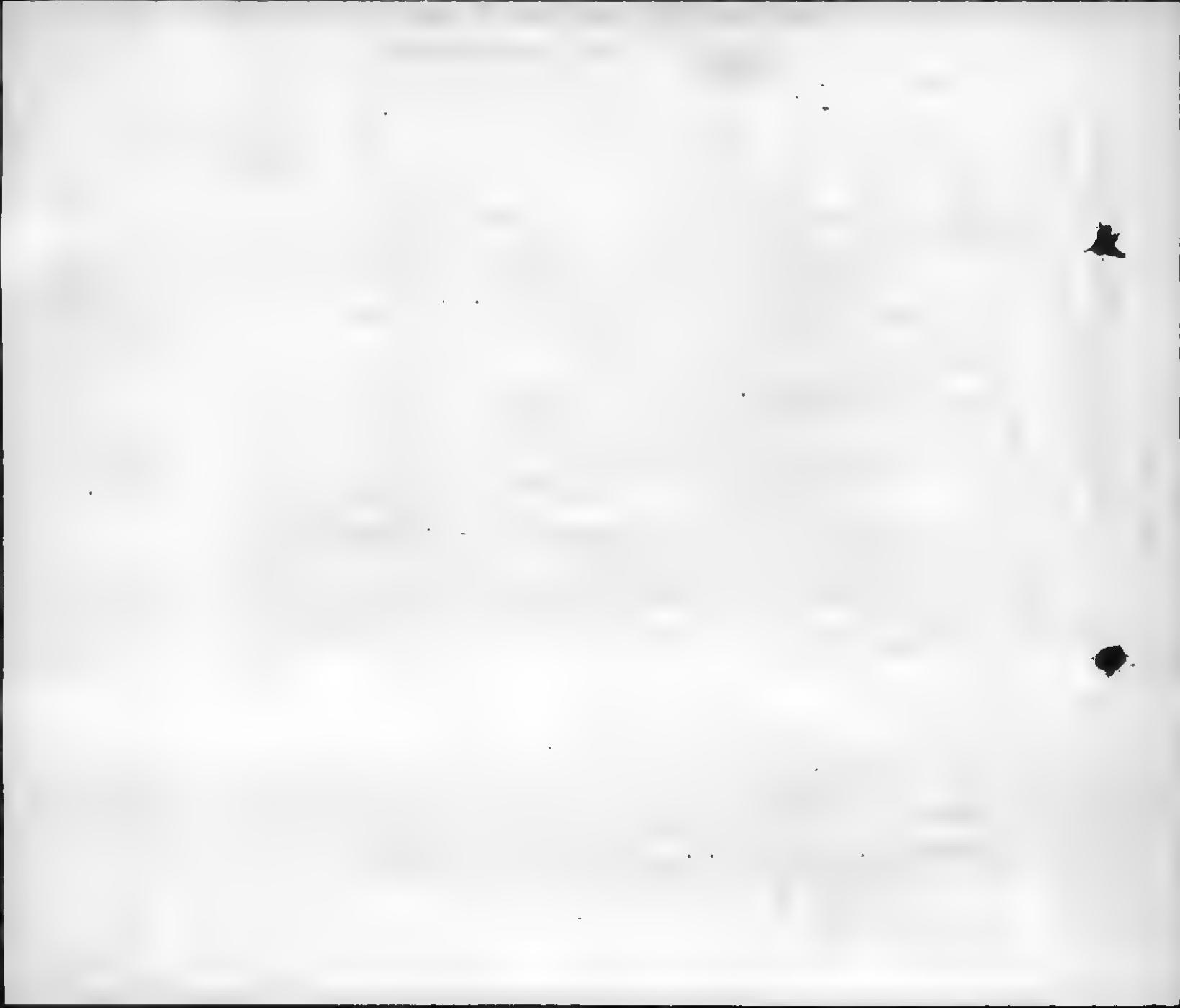
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8533

CERTIFICATE OF DEATH

Reg. Dist. No. 08543

1. PLACE OF DEATH a. COUNTY Wicomico		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury, Maryland		c. LENGTH OF STAY IN 1b 23 days		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Centerville, Maryland		
3. NAME OF DECEASED (Type or print) John		First Charles	Middle Rozier	
4. DATE OF DEATH July 12, 1958		Month July	Day 12	
5. SEX Male		6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH Dec. 1, 1879		9. AGE (In years old birthday) 78 yrs.	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumber		10b. KIND OF BUSINESS OR INDUSTRY unk	11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME William H. Rozier		14. MOTHER'S MAIDEN NAME Laura Chamberlain		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no; unknown) unk		16. SOCIAL SECURITY NO. 215-12-625	17. INFORMANT Address Hospital Records, Salisbury, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)		Carcinoma of prostate with Metastases DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Arteriosclerotic Cardio-vascular disease; DUE TO quadriplegia (c)		
		INTERVAL BETWEEN ONSET AND DEATH 8 yrs.		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour a. m. p. m.		Month 19	Year Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from June 19, 1958, to July 12, 1958, that I last saw the deceased alive on July 12, 1958, and that death occurred at 6:35 PM, from the causes and on the date stated above. ACTUAL SIGNATURE G. Kosmahly, M.D.		ADDRESS (Street, city or town, state) Salisbury, Maryland DATE SIGNED 6/13/58		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 17, 1958	22c. NAME OF CEMETERY OR CREMATORIUM Chesterfield Cemetery	22d. LOCATION (City, town, or county) Centerville, Maryland (State)
23. FUNERAL DIRECTOR'S SIGNATURE J. J. Batten, Jr.		ADDRESS 1520 Batten Bros. (1520 Batts), Centerville, Maryland	24a. REG'D BY REGISTRAR DATE JUL 17 '58	24b. REGISTRAR'S SIGNATURE Ole L. French



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Pg 1 M-251 7-11-58 et

118544

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Wicomico		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury, Maryland		c. LENGTH OF STAY IN lb 2yrs 6mo 27days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury, Maryland				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital		d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Lucy		First	Middle	Lost	4. DATE OF DEATH Ruark	Month July	Day 6	Year 19 58
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 26, 1881	9. AGE (In years last birthday) 78 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min		11. IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Frederick Hastings		14. MOTHER'S MAIDEN NAME Mary Frances Taylor						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) unk		16. SOCIAL SECURITY NO. unk		17. INFORMANT Mr. Rollie W. Hastings (Brother) Address Hospital Records DHSH Salisbury, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		Coronary thrombosis		INTERVAL BETWEEN ONSET AND DEATH 5 min.				
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first.		(b) Arteriosclerotic cardiovascular disease				?		
(c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes mellitus						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from Dec. 8, 1955, to July 6, 1958, that I last saw the deceased alive on July 6, 1958, and that death occurred at 3:25 A.M. from the causes and on the date stated above.						ADDRESS (Street, city or town, state) Salisbury, Maryland		
ACTUAL SIGNATURE V. Juerman, M.D.						DATE SIGNED 7/6/58		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 8, 1958		22c. NAME OF CEMETERY OR CREMATORIUM Parsons Cemetery		22d. LOCATION (City, town, or county) Salisbury, Maryland (State)		
23. FUNERAL DIRECTOR'S SIGNATURE Holloway & Salisbury Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE JUL 9 '58		24b. REGISTRAR'S SIGNATURE A. Deasech		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as a burial-trust permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death - Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as a burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

V5 A15 (4)
 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8535

CERTIFICATE OF DEATH

08545

Reg. Dist. No.

1. PLACE OF DEATH o COUNTY <i>Nicomico</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o STATE <i>MARYLAND</i>		b. COUNTY <i>Nicomico</i>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Salisbury</i>		c. LENGTH OF STAY IN 1b <i>50 DAYS</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Salisbury</i>						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Maryland General Hospital</i>		d. STREET ADDRESS <i>1610 CAMDEN AVE</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print)		First <i>Gertrude</i>	Middle <i>CLARK</i>	Last <i>Ryder</i>	4. DATE OF DEATH <i>July 10 1958</i>	Month <i>July</i>	Day <i>10</i>	Year <i>1958</i>		
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept. 16, 1881</i>	9. AGE (In years b. birthday yrs.) <i>78 yrs.</i>	10. UNDER 1 YEAR IF UNDER 24 HRS Months <i>0</i>	Days <i>0</i>	Hours <i>0</i>	Min. <i>0</i>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>NURSING</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>PRACTICAL</i>		11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>				
13. FATHER'S NAME <i>HENRY CLARK</i>		14. MOTHER'S MARRIED NAME <i>MARY TYLER</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>NONE</i>				
17. INFORMANT <i>MRS. BLANCHE CAREY, SAME</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>acute myocardial infarction</i> DUE TO <i>coronary artery thrombosis & myocardial infarction</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>ASCV Disease</i> DUE TO (c) <i>ASCV Disease</i>		19. INTERVAL BETWEEN ONSET AND DEATH <i>1 hour</i>		20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			20. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>Salisbury, Maryland</i>	(County) <i>Wicomico Co.</i>	(State) <i>Maryland</i>
21. I certify that I attended the deceased from _____ to _____, that I last saw the deceased alive on _____, and that death occurred at _____ from the causes and on the date stated above.						ADDRESS (Street, city or town, state) <i>211 Maryland Ave, Salisbury, Md.</i>		DATE SIGNED <i>7/10/58</i>		
ACTUAL SIGNATURE <i>O.J. BURTON</i>		PHYSICIAN'S NAME (Type) <i>O.J. BURTON</i>		22b. DATE THEREOF <i>7/14/1958</i>		22c. NAME OF CEMETERY OR CREMATORY <i>LORRAINE PARK CEM.</i>		22d. LOCATION (City, town, or county) <i>BALTIMORE, MARYLAND</i>		(State) <i>Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Hill Johnson, Salisbury, Maryland.</i>		ADDRESS <i>Norman F. Baker,</i>		24a. REC'D BY REGISTRAR DATE <i>JUL 15 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Out eaen</i>				



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05546

8554

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bivalve		c. LENGTH OF STAY IN 1b 23 yrs.		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Wicomico	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bivalve		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) FREIDRICH		First WILHELM	Middle SCHMIDT	Lost	4. DATE OF DEATH July 17	Month July	Day 17	Year 1958	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 1/22/1887	9. AGE (In years last birthday) 71	10. IF UNDER 1 YEAR Months 5	11. IF UNDER 24 HRS Days 25	Hours Min		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own Farm		11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknoun					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) No		16. SOCIAL SECURITY NO. 217-28-4988		17. INFORMANT Mrs Edythe Schmidt, Bivalve, Maryland		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)		Chronic Myocarditis				INTERVAL BETWEEN ONSET AND DEATH 1 year			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED White Not white of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hebron - MD		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from July 14th, 1958 to July 14th, 1958 that I last saw the deceased alive on July 14th, 1958 , and that death occurred at 12:40 PM , from the causes and on the date stated above.				ADDRESS (Street, city or town, state) Hebron - MD		DATE SIGNED July			
ACTUAL SIGNATURE William Emerich									
PHYSICIAN'S NAME (Type) William Emerich									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/19/58		22c. NAME OF CEMETERY OR CREMATORIUM St. Marys Cem.		22d. LOCATION (City, town, or county) Tyaskin, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE C. J. Messick		ADDRESS Bivalve, Maryland		24a. REC'D BY REGISTRAR DATE JUL 25 '58		24b. REGISTRAR'S SIGNATURE Alt eden			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this cert. has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as a burial transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08547

8536 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico		2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) a. STATE Salisbury, Md.				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 4½ Years				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springhill Sanitarium		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Grant		First Sexton	Middle 			
4. DATE OF DEATH Month 7 Day 31 Year 1958		Last 	Month Day Year 19			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-3-1868			
9. AGE (In years lost birthday) yrs. 90		10. IF UNDER 1 YEAR Months Days 	11. IF UNDER 24 HRS Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Salesman		10b. KIND OF BUSINESS OR INDUSTRY American Fruit				
10c. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U. S. A.				
13. FATHER'S NAME Jason Sexton		14. MOTHER'S MAIDEN NAME Hester Warner				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-01-9426	17. INFORMANT Mrs. Hester S. Redden, Greensboro, Pa. Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>Cerebral Hemorrhage</i> <i>Gastrointestinal Hemorrhage</i>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Bilateral hyper trophy Prostate		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>7-29-1958</i>				
20c. TIME OF INJURY Hour 9 . a.m.	Day 19	Year 1958	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 116 E. Main St., Salisbury, Md.	(County)	(State)
21. I certify that I attended the deceased from alive on 7-29-1958 to 7-31-1958 , that I last saw the deceased and that death occurred at 7:15 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Salisbury, Md.		DATE SIGNED 8-1-58		
ACTUAL SIGNATURE <i>Philip A. Insley</i>		NAME (Type) Dr. Philip A. Insley				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8/4/58	22c. NAME OF CEMETERY OR CREMATORIUM Rose Hill Cemetery	22d. LOCATION (City, town, or county) Ambridge, Pennsylvania	(State)		
23. FUNERAL DIRECTOR'S SIGNATURE Hill & Johnson Co. Salisbury, Maryland		ADDRESS Norman B. Baker		24a. REC'D BY REGISTRAR DATE AUG 6 1958	24b. REGISTRAR'S SIGNATURE <i>Deborah</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as a burial-tranit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

185548

8537

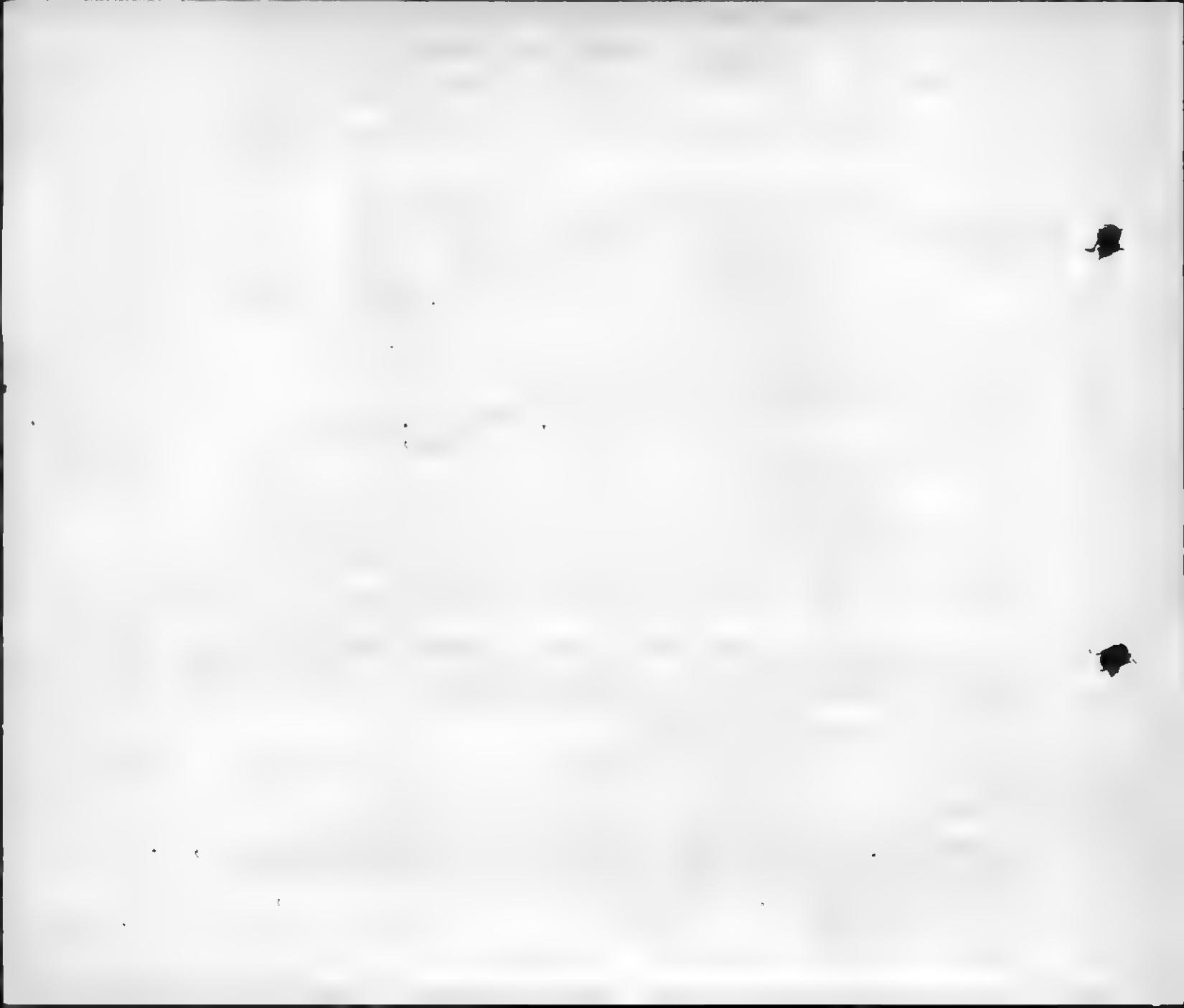
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 702 Howard St		e. STREET ADDRESS 702 Howard St	
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First ARCHIE	Middle WOOD	Last SHOCKLEY
4. DATE OF DEATH	JULY	Month	Day 22
	nd	Year 19	58
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 22, 1893
9. AGE (In years last birthday) 65 yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter-Laborer		10b. KIND OF BUSINESS OR INDUSTRY Construction	
11. BIRTHPLACE (State or foreign country) Bivalve, Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Samuel Shockley		14. MOTHER'S MAIDEN NAME Hester Webster	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) Unk		16. SOCIAL SECURITY NO. Mr. Carroll S. Shockley (Son) 702 Howard St. Address Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 33IX DUE TO <i>Hypertension</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Cerebral vascular accident</i> (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 495X		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>July 1, 1958</i> to <i>July 22, 1958</i> , that I last saw the deceased alive on <i>July 2, 1958</i> , and that death occurred at <i>9:30 AM</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>Dr. William B. Smith</i> ADDRESS (Street, city or town, state) <i>Baltimore, Md.</i> DATE SIGNED <i>July 1958</i>			
PHYSICIAN'S NAME (Type) Dr. William Smith		22a. BURIAL, CREMATION, REMOVAL (Specify) July 25, 1958 22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORIUM Bivalve Cemetery 22d. LOCATION (City, town, or county) Bivalve, Maryland (State)	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		ADDRESS SALTISBURY MARYLAND 24a. REC'D BY REGISTRAR DATE JUL 24 1958 24b. REGISTRAR'S SIGNATURE <i>W. E. L. S.</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as a burial transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8538 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09629

Reg. Dist. No.

1 PLACE OF DEATH
a. COUNTY

Wisconsin

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Watertown

c. LENGTH OF STAY IN lb

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Elmwood General Hospital

3. NAME OF
DECEASED
(Type or print)

First
Dorothy

Middle

Simmons

Last

DATE
OF
DEATH

Month
7

Day
30

Year
1958

5. SEX

6. COLOR OR RACE

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

9. AGE In years
last birthday

22 yrs

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

James

Millington

14. MOTHER'S MAIDEN NAME

Dollie Bishop

Address

15. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no, or unknown)

16. SOCIAL SECURITY NO

17. INFORMANT

Helen Collins, 8A Roddylippe P.L.
Charleston S.C.

INTERVAL BETWEEN
ONSET AND DEATH

24 hrs

410

410

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

Accidental Coma

Diabetes Mellitus

12 g. 60

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

19. WAS AUTOPSY PERFORMED?

YES NO

20a. EXTERNAL CAUSE WAS

PRIMARY OR CONTRIBUTING

CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY

Month, Day, Year

Hour
a. m.
p. m.

19

20d. INJURY OCCURRED

While
at work Not while
at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and in my opinion death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined manner

ACTUAL
SIGNATURE

Kidg. A. Insley

EXAMINER'S
NAME (Type)

Philip A. Insley

DATE SIGNED

8-1-58

22a. BURIAL, CREMATION ON

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORI

22d. LOCATION (City, town, or county)

(State)

REMOVAL (Specify)

8-10-58

Hebrew Presbyterian Cen.

John's Island, S. C.

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

Clinton E. Stewart, West End

ADDRESS

AUG 12 1958

Arthur J. Kramer



10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8539

CERTIFICATE OF DEATH

Reg. Dist. No.

08549

1. PLACE OF DEATH a. COUNTY Micromico	MARYLAND	2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE MARYLAND	b. COUNTY SOMERSET	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SALISBURY	c. LENGTH OF STAY IN lb	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PRINCESS ANN	d. STREET ADDRESS DULANEY FARM, POLKS ROAD.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION PENINSULA GENERAL HOSPITAL	e. STREET ADDRESS DULANEY FARM, POLKS ROAD.	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Willie Mae STRONG	First	Middle	Last	4. DATE OF DEATH July 19 1958
5. SEX FEMALE	6. COLOR OR RACE COLORED	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH July 16 1958	9. AGE (In years, lost birthday) yrs 3
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Robert Strong	14. MOTHER'S MAIDEN NAME Frances Harbin		Address Robert Strong Princess Anne	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No	16. SOCIAL SECURITY NO None	17. INFORMANT None	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia and Intracranial Hemorrhage DUE TO 160.5 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Premature - 3 lbs 14 oz. DUE TO (c) Congenital Heart Disease	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) None	20f. (City or town) None	(County) (State) None
21. I certify that I attended the deceased from July 19, 1958 , to July 19 1958 , that I last saw the deceased alive on July 19, 1958 , and that death occurred at 6:55 PM , from the causes and on the date stated above.				
ACTUAL SIGNATURE William C. Morgan	ADDRESS (Street, city or town, state) Salisbury, Md			
PHYSICIAN'S NAME (Type) None	DATE SIGNED 7/19/58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7-20-58	22c. NAME OF CEMETERY OR CREMATORIAL Polk's Road Cemetery	22d. LOCATION (City, town, or county) Princess Anne	(State) None
23. FUNERAL DIRECTOR'S SIGNATURE Lewis B. Wilson Princess Anne	ADDRESS None	24a. REC'D BY REGISTRAR DATE JUL 23 '58	24b. REGISTRAR'S SIGNATURE W. J. Edwards	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8540

CERTIFICATE OF DEATH

Reg. Dist. No.

08550

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	c LENGTH OF STAY IN lb	c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen Gen. Hospital		d. STREET ADDRESS 509 Liberty St.	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First EDWARD Middle WILLIAM Last TATMAN	4. DATE OF DEATH JULY 15th 1958		
5 SEX Male	6 COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 27, 1911
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman - Ward Baking Co.		9. AGE (In years last birthday) yrs. 47	11. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min
10b. KIND OF BUSINESS OR INDUSTRY Nears, Virginia		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Littleton Tatman		14. MOTHER'S MAIDEN NAME Lula Carey	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes		16. SOCIAL SECURITY NO. 17. INFORMANT W.W. #II 220-10-8324 Mrs. Ethel W. Tatman (Wife) Address 509 Liberty St. Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 491X DUE TO <i>Bronchitis-pneumonia</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH 4 weeks	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.	19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>June 15, 1958</u> to <u>July 15, 1958</u> , that I last saw the deceased alive on <u>July 15, 1958</u> , and that death occurred at <u>M.</u> from the causes and on the date stated above.		ADDRESS (Street, city or town, state)	
ACTUAL SIGNATURE <u>Philip A. Insley</u>	M.D. <u>Salisbury, Md</u>	DATE SIGNED July 16/1958	
PHYSICIAN'S NAME (Type) Dr. Philip A. Insley		116 E. Main St. Salisbury, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>July 18, 1958</u>	22c. NAME OF CEMETERY OR CREMATORIAL Spring Hill MemoryGardens - R.D.#	22d. LOCATION (City, town or county) (State) <u>Salisbury, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY & COMPANY</u>		ADDRESS <u>SALISBURY MARYLAND</u>	24a. REC'D BY REGISTRAR DATE JUL 18 '58
			24b. REGISTRAR'S SIGNATURE <u>John Edward</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8541

CERTIFICATE OF DEATH

Reg. Dist. No.

03551

M

1. PLACE OF DEATH a. COUNTY <i>Wicomico</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Wicomico</i>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Salisbury</i>		c. LENGTH OF STAY IN lb <i>3 Hrs</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bivalve</i>		d. STREET ADDRESS <i>/</i>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Peninsula General Hospital</i>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print)	First <i>Eva</i>	Middle <i>J.</i>	Last <i>Taylor</i>	4. DATE OF DEATH <i>July 26</i>	Month <i>July</i>	Day <i>26</i>	Year <i>1958</i>				
5. SEX <i>Female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>10/26/83</i>	9. AGE (in years last birthday) <i>74 yrs.</i>	IF UNDER 1 YEAR Months <i>7</i>	Days <i>8</i>	IF UNDER 24 HRS. Hours <i>0</i>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Husband's wife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>					
13. FATHER'S NAME <i>Thomas J. Jones</i>		14. MOTHER'S MAIDEN NAME <i>Rose E. Walker</i>		Address <i>21 Taylor, Snow Hill, Md</i>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or no, unknown) <i>No</i>		16. SOCIAL SECURITY NO <i>—</i>		17. INFORMANT <i>Eva Taylor, Snow Hill, Md</i>		INTERVAL BETWEEN ONSET AND DEATH					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute myocardial infarction</i>											
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. <i>Coronary artery disease</i>											
DUE TO (b) <i>—</i>											
DUE TO (c) <i>—</i>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)								20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month Day Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>Salisbury</i>		(County) <i>Wicomico</i>	(State) <i>Md.</i>		
21. I certify that I attended the deceased from <i>July 26, 1958</i> to <i>July 26, 1958</i> , that I last saw the deceased alive on <i>July 26, 1958</i> , and that death occurred at <i>9 AM</i> M, from the causes and on the date stated above.								ADDRESS (Street, city or town, state) <i>Salisbury, Maryland</i>			
ACTUAL SIGNATURE <i>Thomas C. Hill Jr.</i>								DATE SIGNED <i>7/26/58</i>			
PHYSICIAN'S NAME (Type) <i>C. T. Hill Jr.</i>											
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Buried</i>		22b. DATE THEREOF <i>7/27/58</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>St. Mary's</i>		22d. LOCATION (City, town, or county) <i>Tykeskin, Md.</i>		(State) <i>Md.</i>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>C. T. Hill Jr.</i>		ADDRESS <i>Bivalve, Md.</i>		24a. REC'D BY REGISTRAR DATE <i>AUG 5 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Albert Smith</i>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the final transit permit. Then please remove carbon paper. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8542 Items 79 R13-222 8-18-18 et
CERTIFICATE OF DEATH

08552

Reg. Plat. No.

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE			
NICOMICO				MARYLAND			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		b. COUNTY			
SALISBURY							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
SANTA CLARA General Hospital		Princess Anne					
3. NAME OF DECEASED (Type or print)		First	Middle	Lost	4. DATE OF DEATH	Month	Year
MAMIE				Taylor	JULY	21	1958
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> UNKNOWN <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days Hours Min.
Female		White		Approx.	61 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Housewife				Md.		U.S.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME					
David Webster		Leah V. Taylor					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown. If yes, give war or date of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address	
No				Mrs. Norris Dryden		Princess Anne	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH					
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		6 weeks					
+20.1							
DUE TO							
Coronary thrombosis							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)							
DUE TO							
Coronary sclerosis							
(c)		Acute gall bladder disease.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
Month, Day, Year 19							
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at _____, 19_____. M. from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE William H. Fisher M.D.							
PHYSICIAN'S NAME (Type)							
22. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county) (State)	
Burial		7/23/58		Dames Quarter		Dames Quarter Md.	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
C. Lee Hermon, Funeral Director				DATE JUL 24 '58		Quaritch	

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the "In-transit" permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8543

CERTIFICATE OF DEATH

Reg. Dist. No.

08493

1. PLACE OF DEATH a. COUNTY Wicomico		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 1 day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Eden		d. STREET ADDRESS Rourte #2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Peninsula Gen. Hosp.				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Edith	Middle May	Last Waters	4. DATE OF DEATH 7 17 1958	Month 7	Day 17	Year 1958
5. SEX Female	6. COLOR OR RACE AA	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 4-24-1899	9. AGE (In years last birthday) 59 yrs	IF UNDER 1 YEAR Months 59	IF UNDER 24 HRS. Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Bernie Jones				14. MOTHER'S MAIDEN NAME Betsy Tull			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Oscar Waters, Eden, Md. Rt #2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Arteriosclerosis DUE TO (c) Diabetes mellitus PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. INTERVAL BETWEEN ONSET AND DEATH 2 days							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7-17-1958 , to 7-17-1958 , that I last saw the deceased alive on 7-16-1958 , and that death occurred at 1:30 AM , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) 407 Camden Ave, Salisbury, Md. DATE SIGNED 7-17-58							
ACTUAL SIGNATURE Earl Royer M.D.							
PHYSICIAN'S NAME (Type) Dr. Earl L. Royer							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7-20-1958	22c. NAME OF CEMETERY OR Crematorium Friendship Methodist		22d. LOCATION (City, town, or county) Eden, Md. Rt #2 (State)			
23. FUNERAL DIRECTOR'S SIGNATURE J. F. Stewart Funeral Home, Salisbury, Md.				ADDRESS		24a. REC'D BY REGISTRAR JUL 1 8 '58	24b. REGISTRAR'S SIGNATURE John E. Stewart

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the transit permit. Then please remove carbon paper. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8544

CERTIFICATE OF DEATH

Reg. Dist. No

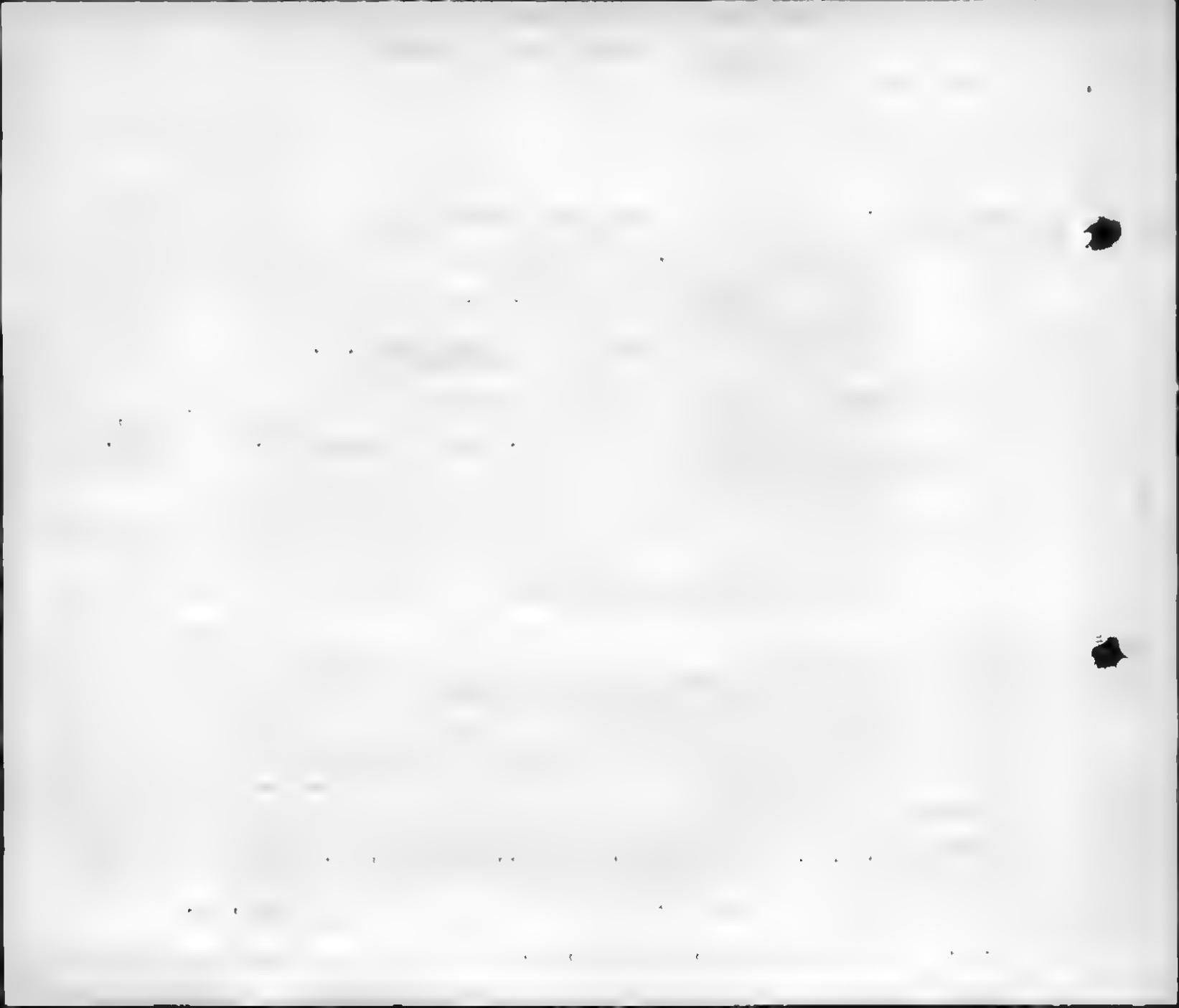
08553

1 PLACE OF DEATH a. COUNTY Wicomico		MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Penna		b. COUNTY Philadelphia		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 2 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Philadelphia		d. STREET ADDRESS 4112 Barring St		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION East Rd. and Norris Sts						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Benjamin		First H.	Middle Weston	Last 	4. DATE OF DEATH 7 7 1958	Month 7	Day 7	Year 1958
5. SEX Male	6. COLOR OR RACE AA	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-26-1888		9. AGE (In years last birthday) 70 yrs.	10. IF UNDER 1 YEAR Months 		IF UNDER 24 HRS Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Postal Carrier		10b. KIND OF BUSINESS OR INDUSTRY Government		11. BIRTHPLACE (State or foreign country) Darlington, S. C.		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Emil Weston		14. MOTHER'S MAIDEN NAME Elvira Brown						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or date of service) 180-16-9648A		17. INFORMANT Mrs. Paige Glaze, East Rd. & Morris St.		Address Salisbury, Md		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. DUE TO (c)				<i>Cerebrovascular disease</i> <i>arteriosclerosis</i>		INTERVAL BETWEEN ONSET AND DEATH 2 months <i>Definite</i>		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 652 W Main		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 7 Dec 1957 to 19 Jan 1958 , that I last saw the deceased alive on 7 Dec 1957 , and that death occurred at 652 W Main , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Philadelphia, Pa. DATE SIGNED 7 Dec 1958								
ACTUAL SIGNATURE E.A. Furnell								
PHYSICIAN'S NAME (Type) Dr. E. A. Furnell 652 W. Main St., Salisbury, Md.								
22a. BURIAL, CREMAT. ON REMOVAL (Specify) Burial		22b. DATE THEREOF 7-11-1958		22c. NAME OF CEMETERY OR CREMATORIUM Mt. Lawn Cemetery		22d. LOCATION (City, town, or county) (State) Philadelphia, Pa.		
23. FUNERAL DIRECTOR'S SIGNATURE J. F. Stewart Funeral Home, Salisbury, Md.		ADDRESS 111 W. Main St.		24a. REC'D BY REGISTRAR REC'D 7-11-1958		24b. REGISTRAR'S SIGNATURE J. F. Stewart		

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as a final-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/55



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be filed with page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

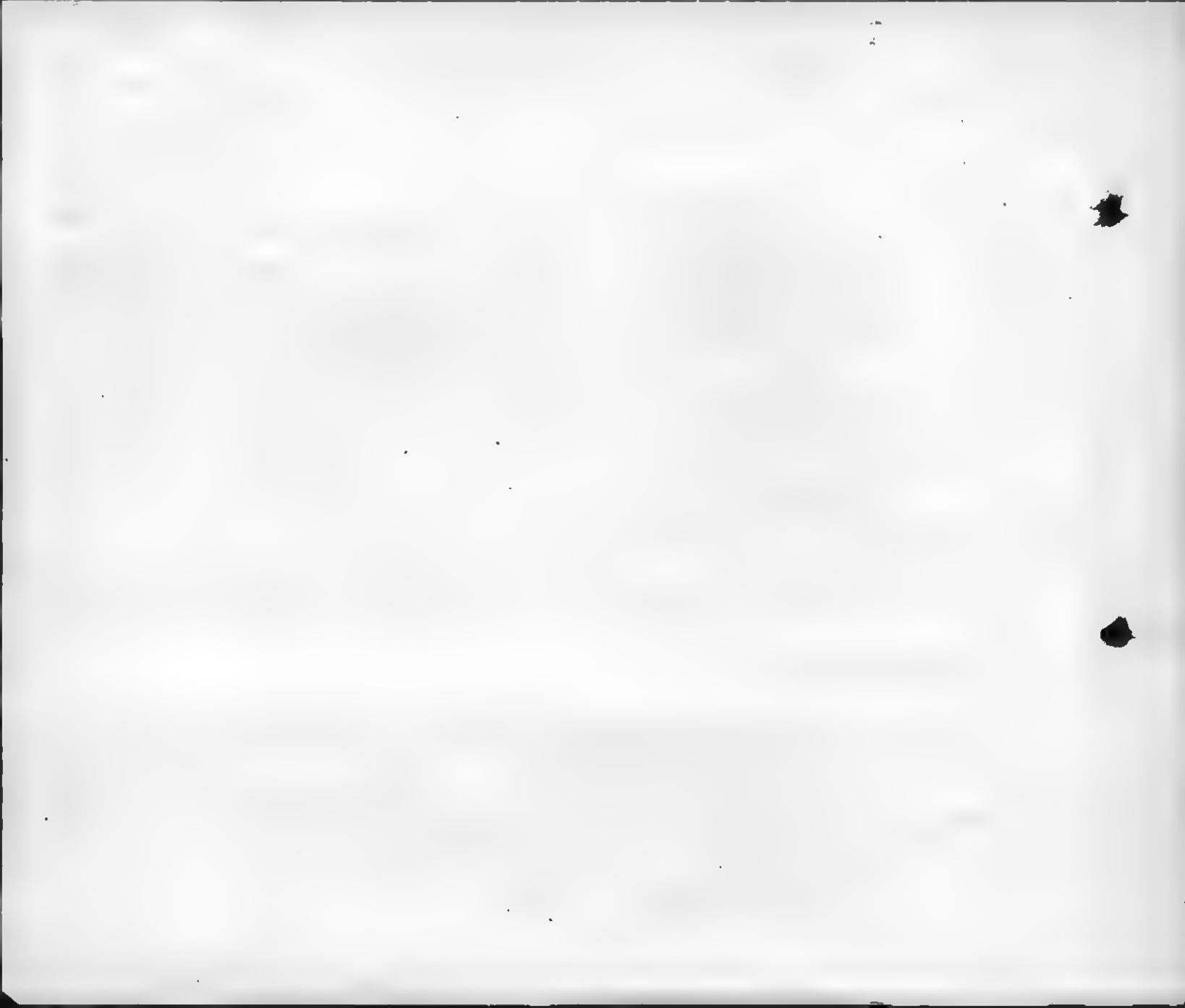
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8545

CERTIFICATE OF DEATH

Reg. Dist. No. 08554

1. PLACE OF DEATH a. COUNTY <i>WICOMICO</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <i>MARYLAND</i>		b. COUNTY <i>SOMERSET</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>JALISBURY</i>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>PRINCESS ANNE</i>		d. STREET ADDRESS <i>192</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>PEWESSEA General HOSPITAL</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Baby Boy</i>		First <i>White</i>	Middle <i></i>	Last <i>White</i>	4. DATE OF DEATH Month <i>JULY</i>	Day <i>25</i>	Year <i>1958</i>
5. SEX <i>MALE</i>		6. COLOR OR RACE <i>Colored</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>JULY 13, 1958</i>	9. AGE (In years last birthday) yr <i>13</i>	10. IF UNDER 1 YEAR Months <i>13</i>	11. IF UNDER 24 HRS Hours <i></i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Henry White</i>		14. MOTHER'S MIDDLE NAME <i>Esther Johnson</i>		Address <i>Henry White Princess Anne 716</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <i>No</i>		16. SOCIAL SECURITY NO		17. INFORMANT <i>Henry White Princess Anne 716</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). <i>Intracranial Hemorrhage</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) DUE TO (c)	
						INTERVAL BETWEEN ONSET AND DEATH <i>(13 Days)</i>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>College Grove Md</i>		20f. (City or town) <i>College Grove</i>	(County) <i>Md</i>
21. I certify that I attended the deceased from <i>7/13</i> , 1958, to <i>July 25</i> , 1958, that I last saw the deceased alive on <i>July 25</i> , 1958, and that death occurred at <i>8 A.M.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>A. J. S. Kellie M.D.</i>		ADDRESS (Street, city or town, state) <i>Medical Center</i>					
PHYSICIAN'S NAME (Type)		DATE SIGNED <i>7/13/58</i>					
22a. BURIAL, CREMATION, OR REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>7/26/58</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>John Wesley</i>		22d. LOCATION (City, town, or county) <i>College Grove Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Wellman & Jones</i>		ADDRESS <i>Princess Anne</i>		24a. REC'D BY REGISTRAR <i>Ma</i>		24b. REGISTRAR'S SIGNATURE <i>Wellman</i>	
				DATE <i>7/28/58</i>			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8555 CERTIFICATE OF DEATH

Reg. Dist. No. 08494

1. PLACE OF DEATH a. COUNTY Wicomico		2. USUAL RESIDENCE (Where deceased lived - If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Powellville		c. LENGTH OF STAY IN lb X Powellville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION At Home		e. STREET ADDRESS at Home	
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First FRANK	Middle HENRY	Last WILLIAMS
4. DATE OF DEATH	Month JULY	Day 22	Year 1958
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 8, 1887
9. AGE (In years lost birthday yrs.) 71		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chicken Grower		10b. KIND OF BUSINESS OR INDUSTRY Chickens	
11. BIRTHPLACE (State or foreign country) Worcester Co. Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Isaac H. Williams		14. MOTHER'S MAIDEN NAME Annie XXXXXX Mae Dennis	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) Unk		16. SOCIAL SECURITY NO.	
17. INFORMANT Mr. Roland C. Williams (Son) Pocomoke, Maryland		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Occlusion INTERVAL BETWEEN ONSET AND DEATH 2 days	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c) Arteriosclerotic Cardiovascular Dis. 3 yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4/15, 1958 to 7/22, 1958, that I last saw the deceased alive on 7/20, 1958, and that death occurred at 8:30 A.M., from the causes and on the date stated above. ACTUAL SIGNATURE Dr. Rufus S. Gardner Jr. M.D.		ADDRESS (Street, city or town, state) Pine Bluff Rd. Salisbury, Maryland DATE SIGNED July 7/23/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 24/58	
22c. NAME OF CEMETERY OR CREMATORIUM St. Johns Cemetery		22d. LOCATION (City, town, or county) Powellville, Maryland (State)	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		ADDRESS SALISBURY MARYLAND	
		24a. REC'D BY REGISTRAR DATE JUL 24 '58	
		24b. REGISTRAR'S SIGNATURE Rufus S. Gardner Jr.	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8546

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08495

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be sent as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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1. PLACE OF DEATH a. COUNTY Wicomico		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Talbot		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Saltisbury		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton		d. STREET ADDRESS 438 South Street		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Maggie		First 	Middle Williams	Lost	4. DATE OF DEATH 7-7-58	Month 7	Day 6	Year 1958
5. SEX F		6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH 8-9-12	9. AGE (in years and birthday) 45 yrs.	IF UNDER 1 YEAR Months 	IF UNDER 24 HRS. Hours 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House work		10b. KIND OF BUSINESS OR INDUSTRY Domestic		11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Joe Simmons		14. MOTHER'S MAIDEN NAME Georgie Lankston		Address Mrs. Hilda Williams, EASTON, MD.				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 244-18-5703		17. INFORMANT 		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Pulmonary edema		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. 260 X		DUE TO Coronary occlusion		INTERVAL BETWEEN ONSET AND DEATH Sudden				
(b) DUE TO Diabetes mellitus				24 hours				
(c)				Years				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour p. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, Farm, factory, street, office bldg., etc.) Easton	20f. (City or town) Easton	(County) 	(State) MD		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <i>Earl T. Royer</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 7-6-58				
EXAMINER'S NAME (Type) Earl T. Royer, M.D.								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/10/58	22c. NAME OF CEMETERY OR CREMATORIAL Richards Cem	22d. LOCATION (City, town, or county) Easton		(State) MD		
23. FUNERAL DIRECTOR'S SIGNATURE <i>James B. Dorrell, Easton, Md.</i>		ADDRESS 		24a. REC'D BY REGISTRAR 	24b. REGISTRAR'S SIGNATURE aw French	DATE JUL 8 '58		

THE COUNCIL OF THE STATE OF TEXAS, ADOPTED
THE 20TH DAY OF MAY, 1935.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8556 CERTIFICATE OF DEATH

08555

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Wicomico				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fruitland		c. LENGTH OF STAY IN 1b all her life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Fruitland		d. STREET ADDRESS Church Street		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Church Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Henreitta		First Wright	Middle R	4. DATE OF DEATH 7 25 1958	Month 7	Day 25	Year 1958	
5. SEX Female	6. COLOR OR RACE AA	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-15-1892		9. AGE (In years last birthday) 66 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Heme		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Henry Criesfield				14. MOTHER'S MAIDEN NAME Mamie Lankford				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Mary Hutt, Church St., Fruitland, Md.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443 X DUE TO Renal Failure INTERVAL BETWEEN Conditions, if any, which gave rise to immediate onset and death cause (a), stating the underlying cause last. (b) Hypertension C.U. Disease 3 months (c) Hypertension 5 years PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Rt #1 Salisbury Wicomico Md		(City or town) Rt #1 Salisbury Wicomico Md (County) Wicomico (State) Md		
21. I certify that I attended the deceased from March , 1958, to July 24, 1958 , that I last saw the deceased alive on July 23, 1958 , and that death occurred at 10 AM M. from the causes and on the date stated above. ACTUAL SIGNATURE G. Herbert Sembley M.D. ADDRESS (Street, city or town, state) 400 East Church St. Salisbury, Maryland DATE SIGNED 7/28/58								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-28-1958		22c. NAME OF CEMETERY OR CREMATORIUM Mt. Calvary Cemetery		22d. LOCATION (City, town, or county) Fruitland, Maryland (State)		
23. FUNERAL DIRECTOR'S SIGNATURE J. F. Stewart Funeral Home, Salisbury, Md.				ADDRESS		24a. REC'D BY REGISTRAR JUL 31 '58	24b. REGISTRAR'S SIGNATURE Albertus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with Page 3 should be detached for use as the Visitation permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

WILSON COUNTY STATE PENITENTIARY - KENYON - VANDERBILT, JR.

1998 CERTIFICATE OF DEATH